Coalition of Women Living with HIV and AIDS (COWLHA)

BASELINE REPORT ON INTIMATE PARTNER VIOLENCE AMONGST PEOPLE LIVING WITH HIV

Made possible with financial assistance from

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ABBREVIATIONS

ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARVs	Antiretroviral Drugs
COWLHA	Coalition Of Women Living With HIV and AIDS
FGD	Focus Group Discussion
GBV	Gender Based Violence
HTC	HIV Testing and Counselling
IPV	Intimate Partner Violence
OI	Opportunistic Infection
PEP	Post Exposure prophylaxis
PLHIV	People Living With HIV
PMTCT	Prevention of Mother-to-Child Transmission
TA	Traditional Authority
VSU	Victim Support Unit

EXECUTIVE SUMMARY

This study was sanctioned by the Coalition of Women Living with HIV and AIDS COWLHA in order to collect baseline information on the incidences and forms of Intimate Partner Violence (IPV) amongst PLHIV in Ntchisi, Salima, Thyolo, Nsanje, Rumphi and Karonga districts.

The study used a semi structured quantitative questionnaire and Focus Group Discussions (FGDs) as the major data collection tools. Overall 361 people were consulted in the 6 districts covering 17 Traditional Authorities (TAs) including People Living with HIV (PLHIV) belonging to Support Groups, local and religious leaders and service providers in the HIV sector.

The results of the study reveal that Support Groups, who were the main entry point to the study, are mainly patronized by women. Men and young people lag behind in all the districts. It also revealed that more women are involved in HIV Testing (HTC) than men. The latter wait until they are very sick in order to undergo HTC. Consequently, couple Counselling is low in all districts with only 27% of couple Counselling taking place if it is female partner initiated while it is at 56% when it is male initiated. This shows that decisions on couple Counselling are largely dominated and influenced by male partners in a relationship.

In terms of IPV, the study reveals that 20% of the PLHIV suffered physical violence, 50% were subjected to psychological abuse and 41% suffered from sexual abuse. Psychological abuse is the most dominant form of IPV and verbal abuse was the most common form of psychological abuse affecting 17% of the respondents. Men are more susceptible to verbal abuse than women and 22% of them suffered from verbal abuse against 16% of the women in intimate partnerships.

Other dominant forms of psychological IPV include reporting home late, observed in 11% of the respondents and is perpetrated largely by men; divorce and separation which is mainly perpetrated against women and hiding one's HIV positive status from a partner which was observed in 9% of the respondents.

Sexual abuse was reported in 41% of the respondents and the most common sexual IPV type was forcing a partner to have sex without a condom. This was reported in 25% of the respondents and is mainly perpetrated by men on women. Total refusal to have sex with a partner, 16% and proposing to have another sexual relationship, observed in 13% of respondents were other dominant form of sexual violence.

HIV testing and Counselling was observed to be origin of IPV with issues like failure to properly communicate HIV positive results to a partner being responsible for IPV. Other important reasons include low couple Counselling due to reluctance by men, failure to disclose HTC results to a partner, external pressures from family and friends and squabbles resulting from blame games on who infected the other partner are all origins on IPV.

There are also cultural practices and rituals such as kulowa kufa, bzade, kutsasa fumbi and kupondera moto, ngozi kapena bwato that propel IPV of sexual nature especially in Thyolo and Nsanje districts.

The key consequences of IPV include refusal to continue ART by the offended partners, inconsistency in following ART and HTC guidelines and advice, poor management of Opportunistic Infections (OIs), unplanned pregnancies, promiscuous behavior and increased exposure to HIV.

IPV resolution mechanisms live alot to be desired at community and district levels. The local leadership is ill prepared for IPV because of lack of knowledge on IPV, low involvement in HTC and HIV issues and lack of confidentiality of the case handling mechanism at local level. Victim Support Unit (VSU) are associated with lack of confidentiality, favouritism and are generally not well perceived by PLHIV.

From the above observations, the study recommends the following:

a. Urgent need for economic empowerment of vulnerable women with HIV, who remain the biggest victims of HIV related IPV.

b. An urgent need to clarify on whether HIV testing at ANC or not compulsory following the integration of PMTCT with ANC services as a means of increasing male involvement in HTC.

c. COWLHA needs to start a serious campaign to inform PLHIV and the general public on the various forms and nature of IPV so as to increase awareness on various forms and nature of IPV.

d. The capacity building of local leaders, marriage counselors and religious leaders in resolution of IPV as well as provision of information to these institutions on HTC, HIV and other related issues will help improve the manner in which IPV is handled at these levels.

e. There is also an urgent need to change the manner in which Counselling is provided to discordant and concordant couples. These require continued periodic comprehensive Counselling in order to manage the post HIV+ era.

f. For IPV victims to properly report cases, there is urgent need to popularize the use of Community and Police VSU as well as improve their confidentiality and follow up mechanisms on complaints lodged at these institutions.

g. In order to target people in white collar jobs who are living with HIV and other educated PLHIV, there is need to design a strategy that goes beyond the Support Groups because these groups rarely patronize any support groups.

1.0 INTRODUCTION AND BACKGROUND

Coalition of Women Living with HIV (COWLHA) is a Malawian organization conceived to create a united voice of women and girls living with HIV and AIDS in addressing issues affecting them. It has implemented various projects aimed at addressing issues affecting women and girls living with HIV and AIDS since 2006. COWLHA has received a grant from United Nations Trust Fund to End Violence Against Women to implement a three-year project aimed at addressing violence against women in 12 districts. The goal of the project is *to prevent intimate partner violence for women living with HIV and create an enabling environment for the promotion of women's rights.* The key objectives for the project are as follows:

I. To reduce intimate partner violence against women;
II. To increase knowledge levels of harmful practices and women's rights;
III. To enhance the capacity of COWLHA structures in gender and HIV and AIDS programming;
IV. To enhance partnerships and networking on the elimination of violence against women

2.0 OBJECTIVES AND SCOPE OF THE BASELINE STUDY

The objectives of the consultancy are as follows:

I. To collect baseline data on prevailing community demographics, gender roles and norms, violence against women, sexual attitudes, communication and behaviours, existing structures on addressing violence against women, HIV knowledge and stigma and discrimination from the targeted districts

II. To develop quantitative and qualitative indicators for measuring project progress in the course of implementation

The full scope of the assignment involved a literature review of project and other documents, design of baseline data collection tools, supervision of data collection processes, data entry and analysis, report writing and designing monitoring tools of the project based on the baseline findings.

3.0 METHODOLOGICAL APPROACH TO THE BASELINE STUDY

In order to get views that reflect the whole IPV spectrum, interviews and consultations were done at personal level amongst PLHIV in Support Groups, at group level using a Focus Group approach and at Institutional Level where Officers at Victim Support Units , Traditional Leaders, Church leaders and other actors in key institutions were also interviewed.

Overall, 254 people were interviewed during personal interviews and 107 during Focus Group Discussion. The study covered 6 districts of Salima, Ntchisi, Thyolo, Nsanje, Karonga and Rumphi, extending to over 17 Traditional Authorities of Kalumo and Malenga in Ntchisi District, TAs Salima, Maganga, Kalonga, Ndindi and Kambwiri in Salima district, TAs Kyungu, Kilipula and Wasambo in Karonga district, TAs Malemia and Tengani in Nsanje district, Bvumbwe and Nchilamwera in Thyolo and TA Chikulamayembe in Rumphi. Table 1 below has details on the district sample distribution for the personal interviews.

TABLE 1: Sample Distribution by District

	DISTRICT	Frequency	Percent
Valid	Ntchisi	40	15.7
	Salima	43	16.9
	Thyolo	35	13.8
	Nsanje	33	13.0
	Karonga	57	22.4
	Rumphi	46	18.1
	TOTAL	**254**	**100.0**

In addition to the above, 107 people were consulted by way of Focus Group Discussions as outlined in table 2 below.

TABLE 2: number of people consulted during FGDs

Respondent Category	Number Consulted
Men	26
Women	60
Traditional and religious leaders	21
TOTAL	**107**

Quantitative data was analyzed using the Statistical Package for Social Scientists (SPSS) where graphs, percentages, counts and cross-tabulations were derived and included in the findings. Qualitative data from Focus Group Discussions (FGDs) was transcribed and used to beef up the quantitative statistics.

4.0 KEY BASELINE RESULTS ON THE NATURE, TYPES AND INCIDENCE OF INTIMATE PARTNER VIOLENCE (IPV) AMONGST PEOPLE LIVING WITH HIV (PLHIV)

This section outlines key results of the quantitative and qualitative study on Intimate Partner Violence (IPV) with HIV and AIDS origins or undertones. It first defines the key social and economic characteristics of people interviewed during the study. Thereafter it outlines the key types of violence that are perpetrated on people in intimate relationships due to their HIV status. It equally tackles the levels of incidence of each type of violence. Issues of traditional practices that also fuel IPV or rights abuses have also been looked into. Finally the issue of resolution of conflicts emanating from IPV are also covered in terms of what is currently in place as well as proposals for improvement.

4.1 SOCIAL AND ECONOMIC CHARACTERISTICS OF PLHIV IN SUPPORT GROUPS

Before a full discussion on the social and economic characteristics of PLHIV, it had to be pointed out that the majority of people consulted during the study were women. In fact women constituted 80% of PLHIV consulted during personal interviews while during FGDs, the women outnumbered men by a ratio of 3:1.

Table 3 below shows the proportions of PLHIV consulted during personal interviews and FGDs.

TABLE 3: Gender of respondents consulted during personal interviews

		Frequency	Percentage	Valid Percent
Valid	Male	51	20%	20%
	Female	203	80%	80%
	TOTAL	**254** `	**100.0**	**100.0**
Numbers met during FGDs				
	Men	26	24%	24%
	Women	60	56%	56%
	Chiefs and			
	Religious Leaders	21	20%	20%
	Total	**107**	**100%**	**100%**

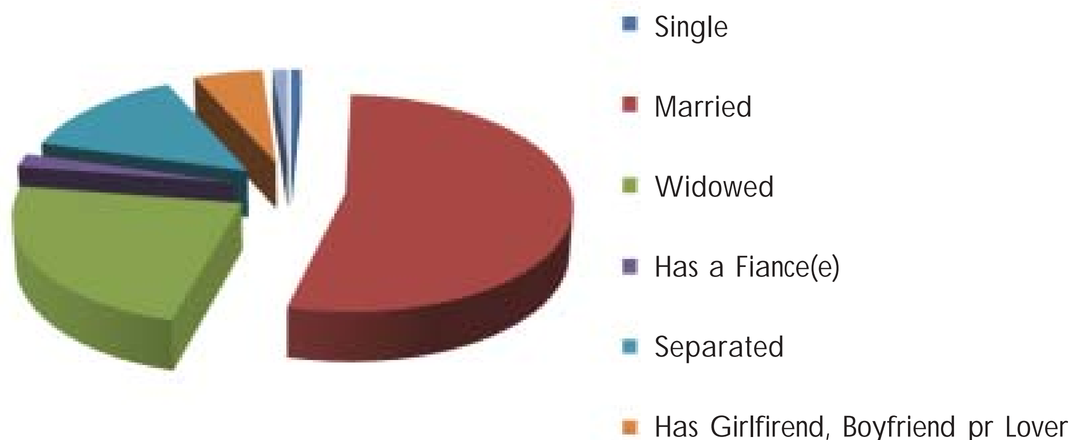
The low numbers of men is a reflection of low participation of men in Support Groups, and their overall low participation in HIV Testing and Counselling as well as their overall openness whenever they are found HIV positive. This is discussed in further detail in the upcoming chapters, however, this definitely suggests that for men to be reached with IPV interventions, there is need to devise a strategy to increase their patronage at Support groups or to design a strategy that goes beyond the Support Groups.

4.1.1 SOCIAL STATUS OF PLHIV IN SUPPORT GROUPS

The social status of partners involved in intimate relationships where at least one partner is HIV positive is an integral part of factors that can help us properly understand IPV, where it occurs, how and under what circumstances. That is why, it was decided that there is need for proper definition of what an intimate relationship entails and what level of intimacy do the partners have. The results of the assessment reveal that the majority of PLHIV that belong to Support Groups are married. In fact 53% of the respondents were married. The second majority, at around 23% are widowed while those who were on separation

constituted 14% of the sample of respondents met during personal interviews. Note that only 2 PLHIV that were single were met and interviewed during personal interviews. Other PLHIV not well represented in the sample include those in latter stages of courtship (with a fiancé or fiancée) and those who were divorced who contributed only 2% and 1%, respectively to the sample as can be seen in Figure 1 below.

FIGURE 1: Social Status of PLHIV Consulted in personal interviews

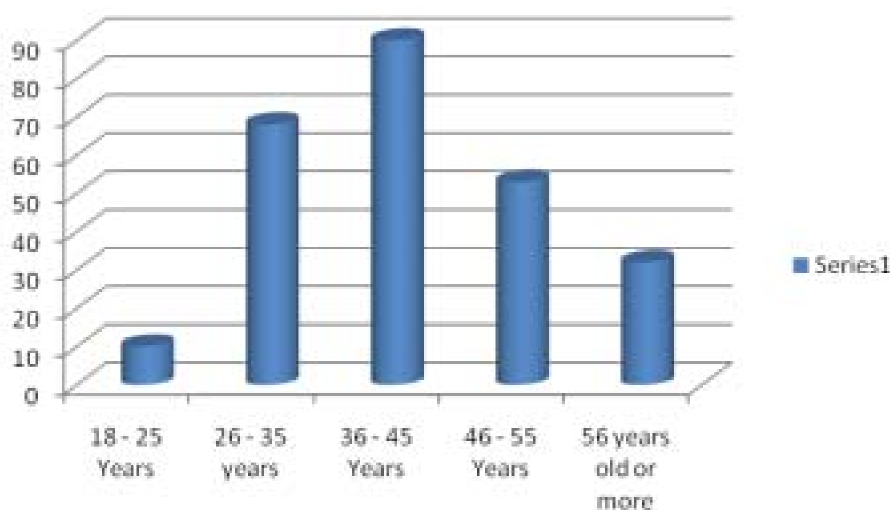


What is striking in the above figure are the low numbers of single PLHIV. Also, only a limited number of people in courtship actually belong to support groups. This is a big problem and poses serious challenges in targeting these people with interventions that aim at reducing or eliminating IPV because this category of PLHIV are invisible. Other efforts outside the support group have to be employed in order to reach this group. The ages of the PLHIV also point to the absence of younger people in Support groups as discussed in the next chapter. Therefore, it has to be said again like in the last chapter that, any comprehensive IPV prevention and mitigation strategy has to go beyond Support groups in order to reach young people especially those below the age of 25.

4.1.2 AGES OF PLHIV MET DURING PERSONAL INTERVIEWS

An analysis of the age groups of PLHIV met during personal interviews reveals that the majority of the people who belong to Support groups are between 36 – 45 years old. These constituted about 36% of the respondents. The second majority, at about 21% were between 46 – 55 years. The least majority are in those between 18 – 25 years who constituted just about 4% of the sample. There was no one below 18 years old that was consulted during personal interviews. Figure 2 below has more details.

FIGURE 2: Ages of respondents consulted during personal interviews



As has been seen in Figure 2, there is low participation of young people in Support Groups. This was confirmed during Focus Group Discussions where it was pointed out that young men and women, especially those who are not married, do not prefer to live openly with HIV because of high levels of stigma and more importantly in order to maintain their chances of getting a suitor. Most young people with known HIV status to the community are usually subjects of high levels of stigma. Whenever they meet a potential partner, someone goes behind their backs to warn them due to their HIV positive status. This discourages openness amongst young PLHIV as this reduces their chances of fulfilling their sexual and social needs. This is also confirmed in the earlier statistics in Table 4 where only 2 interviewees or about 1% of the sample were single. Here again, a strategy for IPV mitigation and prevention has to go beyond Support groups in order to include young people in the interventions.

4.1.3 EDUCATIONAL QUALIFICATIONS OF PLHIV IN SUPPORT GROUPS

The majority of the PLHIV who belong to various Support Groups in all the districts have low educational qualifications. The biggest majority have only attained senior primary education (Standards 4 – 8). These constituted 43% of the respondents while the second largest group, at 23%, has only attained a Junior Certificate level of education. Only 11% had finished their secondary education and have attained the Malawi School Certificate of Education (MSCE) as can be seen in table 4 below.

TABLE 4: Educational level of respondents in persona interviews

	Education level	Frequency	Percentage
Valid	No formal Education	33	13%
	Standard 1 - 3	23	9%
	Standard 4 - 8	107	43%
	Junior Certificate of Education	61	24%
	Malawi School Certificate of Education	27	11%
	Diploma - Degree	1	0.4%
	Total	**252**	**100%**

Also note from table 4 above that 13% of PLHIV interviewed in Support Groups were without any formal education. This is an interesting finding because it helps to properly define what manner of people can be found in Support Groups. The low levels of education above puts the PLHIV at low level of self esteem and more likely to have problems in asserting the respect of their rights and entitlements in addition to low levels of knowledge on the various forms of abuses that may be perpetrated on them by their partners or other members of society. Likewise, they may also have a greater propensity to perpetrate IPV on their partners due to low levels of knowledge especially on rights and responsibilities.

Area observed for further Research:
A comparative Study to determine levels of IPV amongst educated and less educated PLHIV

4.1.4 HOUSEHOLD SIZES OF PLHIV IN SUPPORT GROUPS

An assessment of household sizes for PLHIV is an essential component of the IPV assessment because it allows decision makers in the HIV sector to gauge the number of people in households who are directly or indirectly affected by the abuses and violence between partners or from decisions that are going to be made by the partners in conflict with one another. The study reveals that the majority of the households have between 4 – 6 members. This category contributed 66% to the sample. This is in line with the

national average of 5 people per household. However, it has to be noted that about 21% of the households have household sizes above the national average. These have at least 7 household members as can be seen in table 5 below.

TABLE 5: House hold sizes of respondents met during personal interviews			
	Household size	**Frequency**	**Percentage**
Valid	Less than 3 Household members	34	14%
	4 - 6 Household Members	165	66%
	7 - 10 Household members	44	18%
	More than 10 Household members	8	3%
	Total	**251**	**100.0**

Of particular importance to the understanding of IPV, was the analysis of children in households of PLHIV. This is of particular relevance because children represent the most vulnerable in society. This helps in further understanding how IPV affects children, orphans and other vulnerable household members the potential damage that incidences of IPV have in hindering these vulnerable people from achieving their potential in terms of growth and development. 68% of the households of PLHIV in Support Groups have less than 3 children. These are in majority. The second majority of households have between 4 – 6 children, these coming a distant 27%. Only about 4% of the households have at least 7 children as can be seen in Table 6 below.

TABLE 6: No of children in household			
	No of children in the households of respondents	**Frequency**	**Valid percent**
Valid	3 Children or less	154	68.1
	4 - 6 Children	62	27.4
	7 - 10 children	10	4.4
	TOTAL	**226**	**100.0**
Missing	System	28	
Total		**254**	

The table 6 above shows that whatever poor decisions that may be made by intimate partners of PLHIV are likely to affect children in at least 70% of the households. In other words, over 70% of the Children in households of PLHIV who belong to Support Groups are likely to suffer from IPV related consequences such as divorce, separation, lack of food and other household support especially in households where the partners have unequal empowerment socially and economically.

4.2 NATURE AND TYPES OF INTIMATE PARTNER VIOLENCE

There are many types of violence that have been encountered during the study. These were divided into three distinct categories which include physical violence, psychological violence and sexual violence.

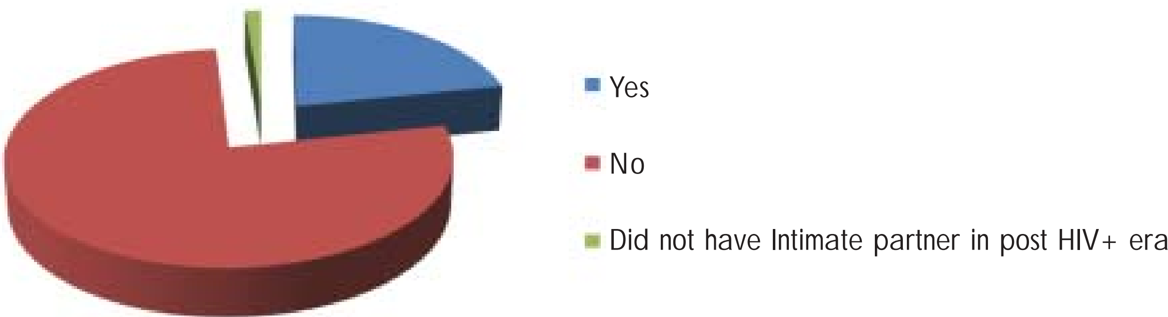
There is also an additional category, which is violence of economic nature whose origin is one's HIV status. Amongst the three types of violence, physical violence is the most visible yet the most uncommon. Its visibility makes it the most easily recognizable because of the evidence it leaves on the victims. However, psychological and sexual violence also happen in most intimate relationships involving PLHIV and is perhaps more frequent than the violence of physical nature. The key types of violence by types are further

4.2.1 PHYSICAL VIOLENCE IN INTIMATE PARTNER RELATIONSHIPS

[1]Physical violence is the intentional use of physical force with the potential for causing death, injury, disability or harm. It includes, but is not limited to, scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, slapping, punching, burning and use of restraints or one's body, size strength against another person.

It was the least observed type of IPV amongst PLHIV and was observed in about 20% of the total respondents in personal interviews. 71% of the respondents did not suffer any kind of physical violence from their intimate partners in the past 12 months. Figure 3 below has more details.

FIGURE 3: Incidents of physical IPV amongst PLHIV in the past 12 months



Fighting with hands was the most common type of physical violence that was observed from 13% of the total respondents. Physical violence involving use of objects was not as common happening to about 3% of the respondents consulted during personal interviews. Scalding with water or oils is least common and was reported in less than 1% of the respondents. The most common mentioned objects that are used in physical violence include sticks, knives and kitchen utensils. Hot or cold water is also used in physical violence as a tool for mounting an assault on someone or simply aimed at bringing shame on a partner without in the case of cold water.

There was no singular dominant factor that causes physical violence amongst PLWHA partners but queries and squabbles amongst partners as to who infected the other with the virus, financial disagreements arising after a partner finds an alternative partner or withdrawal of financial support to punish a partner were all key reasons that provoked incidents of physical violence. Other reasons included queries on extra-marital affairs against HTC advice, altercations involving chasing a partner from a home during divorce or separation and refusal to have sex without a condom. More details on causes of IPV are given under section 5.0 below. However, one has to bear in mind that IPV is common at the realization that one's partner went for HIV testing and has been found HIV positive. Since emotions run high at this time and blame games as to who has infected the other are at their highest, this kind of violence happens more at this point of HIV status realization either by one of the partners or both. Another study conducted by MANET plus in Nkhotakota district reported about 14.2% of assaults happening in PLHIV as a result of their HIV status.

Other types of physical violence encountered include burning someone's organs or features like fingers, hands, or indiscriminately on any part of the body. Where there has been lack of openness amongst

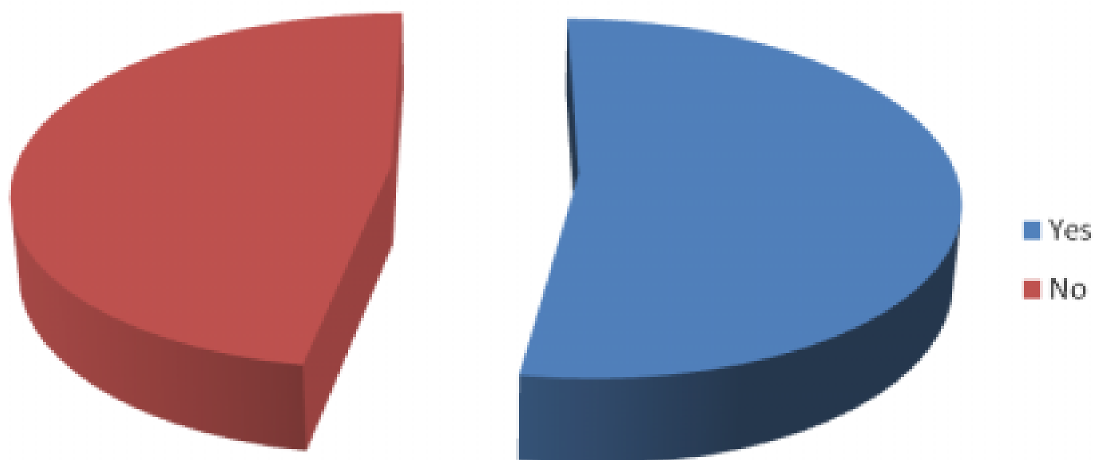
couples such that each partner is not aware of the other's status, throwing away a partners' ARVs was also discussed especially during Focus Group Discussions.

4.2.2 PSYCHOLOGICAL AND EMOTIONAL VIOLENCE

Psychological/ Emotional violence involves trauma to the victim that is caused by acts, threats of acts or coercive tactics. It can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something that will make the victim feel diminished or embarrassed isolating the victim from friends and family and denying the victim access to money and other basic resources[1].

Psychological violence is the most common type of violence and abuse in relationships involving PLHIV. It is a more subtle kind of violence because it rarely leaves short term marks on the bodies of the victims. However signs of this violence can be observed on the countenance of the individual or long term effects like weight loss, disorientation, lack of concentration and other psychological effects. Some immediate signs can sometimes be noted by people who live with and know the victim which may be manifested by irrational behavior, withdrawal from public life and other signs. Other types have potential to have a physical or actional dimensions such as physical withdrawal from a matrimonial household or other observable actions. About 50% of the respondents in personal interviews reported to have suffered psychological violence in the past 12 months, while about 45% had never experienced any psychological violence as can be seen in Figure 4 below.

FIGURE 4: Incidents of psychological abuse amongst PLHIV



[1]www.cdc.gov.violer

Verbal abuse was identified as the most common form of psychological abuse in both personal interviews and during focus group discussions with members of support groups. Another abuse of an intimate partner commonly mentioned in both types of consultations involved reporting home late for reasons whose origin is a partner's or both partner's HIV positive status. This is a common tactic employed mainly by men to force the partner out of a home, or to create suspicion that they have another partner, thereby forcing the current one to make a decision to terminate their relationship. Others still would return late because they have started another intimate relationship as a means of running away from pressures 'piled' upon them by HTC counsel such as use of condoms during sex.

Psychological violence amongst intimate partners has significant gender dimensions with 30 out of 51 men(59%) interviewed reporting to have suffered psychological abuse against 47% (96 out of 201)of the women that reported psychological abuse. Table 7 below had details.

TABLE 7: Gender dimensions of psychological violence

Psychological abuse by gender	Gender of Respondent			
	Response	**Male**	**Female**	**Total**
	Yes	30	96	126
	No	17	96	113
Total		**47**	**192**	**239**

Even though there are more women abused than men, the proportion of men abused against the total number of respondents is greater than that of women. Verbal abuse was said to be more perpetrated by women during focus group discussions. This being the major form of psychological abuse identified during the study. Withdrawal from sexual activity with the partner either due to reported promiscuous behavior or as a response to a consistent late reporting back home was also noted to be a common behavior amongst women with HIV. These two factors are responsible for slanting the statistics in favour of men.
The most common forms of psychological violence and their levels of occurrence in the 12 month period before March 2012 are highlighted in table 8 below.

TABLE 8: The most common forms of psychological violence amongst intimate partners who are HIV positive

	Major forms of psychological violence	Frequency	%
Valid	Verbal abuse	43	16.9
	Partner reporting back home late due to HIV related factors	29	11.4
	Partner no longer interested in sex	14	5.5
	Being refused food	8	3.1
	Stigma and discrimination	6	2.4
	Divorce or Separation	6	2.4
	Withdrawal of Financial Support	5	2.0
	Being stopped doing certain jobs at home	3	1.2
	No longer talking to partner	2	0.8
	Being forced to stop ARVs	2	0.8

Below is a detailed description of the most common types of psychological violence observed during the consultations in both personal interviews and Focus Group Discussions.

4.2.2.1 VERBAL ABUSE

Verbal abuse is the most common type of psychological violence that happens in intimate relationships involving PLHIV. Verbal abuse was observed in about 17% of the respondents in personal interviews in the 12 months from March 2012. It happens at any time and has very diverse causal factors. For intimate partners who have just had an HIV test, the verbal abuse is caused by disagreements on who has been responsible for infecting the other partner. Personal histories of partners are put in the open and any mistakes they might have made in the past are usually mentioned as a source of the HIV in such verbal tirades. The insults involve mainly dehumanizing someone to make them feel less a person or unlikely to live long or sometimes being referred to as a moving corpse because of their HIV status. Some verbal abuse border around denial of a partner who isn't yet tested. Comments like ***'Ma Edzi Anuwo Ndiine Ayi' (This AIDS of yours shouldn't concern me)*** are quite common amongst the untested partners. In certain cases verbal abuse goes to the extent of revealing someone's HIV status to the community in a situation which is commonly referred to as '***kuimilana pachulu'***

Verbal abuse is particularly damaging when it happens soon after an HIV positive test at HTC. It is at this time that they are least prepared for it and are asking themselves so many questions about their lives and the changes they have to make in order to live a fulfilling life with HIV. Later in their post HIV life, those who join Support Groups or a group therapy of some kind, do get galvanized against such abuses because of the strength and encouragement they get from their peers who have endured such abuses in a more non-friendly environment when AIDS was almost taboo.

An analysis of gender dimensions of verbal abuse reveals that 22% of them men suffer verbal abuse against 16% of the women in intimate partnerships where one partner or both are HIV positive. This is consistent with views expressed during focus group discussions where it was pointed out that women seem to be more prolific in talking than any average Malawian man. Women were reported to be responsible for continually talking about an issue until a partner starts reacting by reducing his contact with them. This breeds a partner response through reporting home late or drinking too much and attracts further verbal abuse in the process.

4.2.2.2 REPORTING HOME LATE

Partner who had always been punctual reporting home late was reported by 11% of the respondents and remains the commonest driver of psychological torture amongst partners with HIV and AIDS. It is commonest in relationships that are discordant or where one of the partners hasn't yet gone for an HIV test. Since men resist HIV testing more than women, it is mainly men who report home late. It also happens where a man is HIV negative. As a result of frustration or just finding an excuse to do some things, men find themselves spending more time at drinking joints or would look for a new intimate partner. As a result of this, their time management is affected. In rural areas where there is little approval for such kind of behavior, such men meet their new partners at night. That is why they report back late. At the same time, this acts as a signal to the female partner that their man is having an affair. It triggers other types of abuse, particularly sexual violence where either partner can withdraw from sex or force or reduce the frequency of sex. These sexual abuses are done to punish the perpetrator for coming late or to further punish the female partner for 'bringing' an undesirable HIV result in the family. In certain instances, refusal to accept having sex with a partner who has reported late triggers marital rape and/ or forced sex without a condom.

Reporting home late is a man's thing with only 2% of the men interviewed having suffered the agony of waiting for a partner who doesn't turn up on time against 14% of the women who suffered a similar fate.

4.2.2.3 DIVORCE AND SEPARATION

According to discussions during Focus group Discussions with PLHIV and local leaders, divorce and separation are very common in relationships involving discordant couples. When a man is tested HIV negative, divorce is likely to occur than when a woman is HIV positive. In this study, only one man reported to have been left by a partner on account of his being HIV positive against 5 women that reported the same when it was the man that was found HIV positive. Separation happens mostly in unmarried couples or those in courtship. However, the source of the separation is mostly when one discovers that their partner is HIV positive. When they are not HIV positive themselves, they would decide to leave the partner either by their own volition or due to pressure from their relatives or friends. For partners that live together permanently of semi-permanently discovery of ARVs or some medication that is HIV related may lead to separation. Separation or divorce also occurs when a partner fails to convince the other on the need to use condoms or follow some advice given during HTC.

4.2.2.4 DISCLOSING PARTNERS STATUS TO OTHERS WITHOUT CONSENT

There have been instances where partners would quarrel and, in their anger, would not only verbally abuse a partner, but go further to disclose their HIV positive status to the entire community. This is a common kind of abuse in rural areas of village setting where incidences of ***'kuimilana pachulu'*** or what you would term as ***'undressing or dressing down'*** someone are quite common. Men and women perpetrate or suffer this kind of abuse in equal measure.

4.2.2.5 HIDING ONE'S HIV STATUS FROM AN INTIMATE PARTNER

While some the people who live positively with HIV especially those who belong to Support Groups are known for their openness on their sero-status, not everyone is free to reveal their HIV status. This sometimes becomes necessary in areas where stigma and discrimination of PLHIV. The hiding of one's sero status to an intimate partner is a reality in Malawi and it happens quite often in all districts assessed. In fact, the results show that only 64% of the PLHIV interviewed went for HIV testing without their partners. Furthermore 28% didn't not even inform their partners that they were going for an HIV test and about 9% did not even inform their partner after undergoing HIV testing. This is clear testimony that there is hiding of HIV positive status amongst intimate partners.

Hiding one's status from a partner happens in all manner of relationship. In courtship, for example, one avoids revealing their HIV positive status for fear of losing the partner. Information from Support Groups reveals that men have been associated with taking ARVs at their workplace or hiding them within the household. However, women seem to be the master in hiding sero status because, PLHIV say that they have very little chance of being proposed to by an HIV negative, so everything possible has to be done to keep a man that has developed interest in you. That is why women go as far as hiding ARVs from a partners' discovery in places where a man can rarely suspect. This includes in Maize flour containers (mu ufa), at the neighbours or friend's places. All these actions often lead to further physical violence once discovered. They also lead to separation and often divorce. The implications of this secrecy is poor management of OIs, further HIV transmission as well as more trauma on exposed partners.

4.2.2.6 DELIBERATELY INFECTING PARTNER WITH HIV

This is similar to the abuse described under sexual abuse concerning forcing someone to have unprotected sex or that of hiding one's status to an intimate partner. The only difference with the former is that there is no force involved since the other partner doesn't know that their spouse or lover is HIV positive. With at least 12% having reported to have been forced to have unprotected sex, the issue of deliberate infections of partners is a reality in all districts of study.

4.2.2.7 FORCING AN INTIMATE PARTNER TO GET PREGNANT DESPITE BEING IN POOR HEALTH

HTC advice points to the fact that partners with HIV need to do a careful assessment of a woman's health before they make a decision to have a baby. A woman is advised not to get pregnant very often because this may compromise her health. However, there are incidences where female partners who are HIV positive are forced to become pregnant despite being in a poor or precarious health condition.

Even though a partner may sometimes accept to do this, in certain cases marital rape or partner rape is the mode through which this kind of abuse is forced on an intimate partner. This is common in married couples and is mostly perpetrated by men. In some cases, women may force a man to make them pregnant. In this case, the abuse is self-inflicted. The consequences are of course self defeating.

4.2.2.8 REFUSING A PARTNER TO TOUCH OR SHARE ONE'S OBJECTS AND PROPERTY

When an intimate partner goes for HTC and announces to the other that they have been diagnosed with HIV, some partners immediately go into denial and start applying all sorts of sanctions on the partner. Some of these sanctions involve prohibiting someone from making and using one's bed, allocating their own kitchen utensils and cutlery or doing laundry for the partner. This has the likely effect of having the partner feel unloved or with psychological trauma because such actions are usually associated with verbal abuse. This is perhaps summarized in a story of a Salima woman who was reprimanded by a partner after making his bed. This is what the partner reportedly said ***'ndinanena kale kuti zinthu zanga musamazigwire mungandipatsire AIDS yanuyo' (I already said you don't have to touch my stuff because I don't want to catch your virus)*** Paradoxically, the aggressor has never gone for HTC.

4.2.2.9 LOCKING A PARTNER OUTSIDE

Most men who are in intimate relationships and live in the same house with their spouses are sometimes locked outside the house when they have the habit of returning home late. This coming late is either because they spend a lot of time at a drinking joint or with another lover or spouse. This banishing happens to punish the partner on the suspicion he/she infected the other after getting the virus through alcohol related factors or secret partners. The partner would usually ask you to go back from wherever you are coming from in order to either avoid more sexual contact or just as punishment for being late.

4.2.2.10 BEING DEPRIVED OF FOOD OR REFUSING TO TAKE ONE'S MEALS

When there is reasonable suspicion that a man may have been responsible for infecting his spouse with HIV , a woman sometimes withdraws the provision of food to the man as punishment for his behavior. This usually happens when a couple cannot agree on whether to cut down on risky behaviours or on the number of partners. When the man doesn't show remorse or repentance by not returning home on time, the female partner decides to punish the man by not serving him any food. This, of course, sometimes fuels further violence and sometimes backfires by further pushing the man away into greater irresponsible behavior. 5.2% of the people interviewed during personal interviews reported to have been deprived of food in the past 12 months.

4.2.2.11 REFUSING REPONSIBILITY FOR PREGNANCY BECAUSE PARTNER IS HIV POSITIVE

With the introduction of 'mandatory' HIV testing for women under the new PMTCT regime adopted following guidelines proposed by the WHO in 2010, all pregnant women who are HIV positive are put on ART regardless of the their CD4 Count. This is seen as a more efficacious way of preventing HIV transmission to the unborn child at birth than the single dose Niverapine regimen that has previously been followed. Once a partner is diagnosed HIV positive at ANC, some partners, especially when they are not yet married, would start refusing responsibility for the pregnancy on their own or due to pressure from family and friends. This forces the man to abandon a woman who is HIV positive. This was never attributed to married couples in our discussions with Support Groups. This refusal puts the woman in double trouble as they have to think about how to make adjustments to their lives and strictly follow advice on nutrition, sexuality and sex and other healthy habits that can sustain the life of a pregnant woman on ART. In addition, they have to think **about** a psychological issue of a partner who has withdrawn moral and sometimes even financial support to herself and the unborn child.

4.2.2.13 BACKTRACKING TO FORMALIZE A RELATIONSHIP WITH PARTNER

Couples who are living in non-formalized relationships or cohabiting usually face problems when one or both of them discover that they are HIV positive. As a result of this one of the partners would silently or violently backtrack from formalize their partnership despite prior agreement to do so. This may happen with or without pressure from parents or friends. Words from relatives like *'mukufuna kukwatira kapena kukwatiwa ndi munthu ofa kale' (so you want to marry an already dead person)* are quite common.

Information from FGDs reveal that both men and women manifest this behavior. However, currently more men than women have been observed to be doing this since it is usually women that have an HIV test first.

4.2.2.14 REFUSING ONE TO SEE OWN CHILDREN AFTER SEPARATION OR DIVORCE

Partners that are on marital separation or divorce sometimes refuse each other access to their children. This is a punishment meted on a partner due to other underlying past HIV related disagreements that have led to separation or divorce. Usually feelings by a partner that it was the conduct of the other that may have led to their contracting HIV are responsible for this. Women would also apply this sanction when the male partner is not economically supporting the children after separation.

4.3 ECONOMIC VIOLENCE

Even though economic violence in a relationship where at least one of the partners is HIV positive takes more of a psychological dimension, the monetary aspect of the violence is a greater defining factor. It is perpetrated against partners that are not financially independent. It usually involves withdrawal of economic support to a partner because of disagreements over responsibility for the couples HIV status. It is usually meted on women who have queried the man's behavior as being the cause for the couples' HIV positive status. It usually starts when a man learns that their partner is HIV positive following HTC at a fixed facility, mobile facility or at antenatal clinic. It is also meted on women when they continuously criticize a man's behavior.

This withdrawal of financial support can sometimes extend to businesses operated by a partner and in extreme cases even children can suffer from withdrawal of financial or material support. Cases where a financially dependent partner is refused money to travel to a clinic to collect ARVs, for check up or other medication for their condition have also been observed

In certain couples, a psychologically strong but financially dependent partner, usually a woman, imposes self-benefitting economic sanctions on their financially independent partners once they admit responsibility for infecting their partner with HIV. This involves giving a partner a sense of guilt which propels them to accept certain financial burdens such as being responsible for collecting ARVs and other medicines on behalf of the partner or hiring them a bicycle taxi whenever they have to go for medical check-up or consultation. They are also additionally allocated other unconventional households jobs not in keeping with their gender roles.

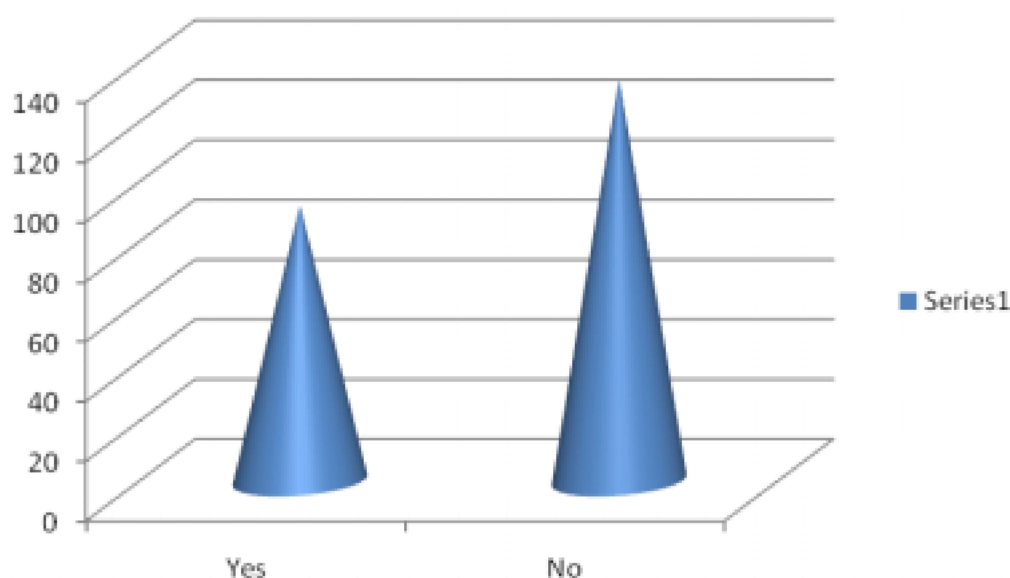
4.4 SEXUAL VIOLENCE AND ABUSE AMONGST INTIMATE PARTNERS WITH HIV

Sexual violence is divided into three categories. Firstly, the use of force to compel a person to engage in sexual acts against his or her will, whether or not the act is completed. Secondly, sexual violence can entail attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act e.g because of illness , disability, or the influence of alcohol or other drugs, or because of intimidation or pressure. Lastly sexual violence can simply entail abusive sexual contacts.

Sex and intimacy are the centre piece of most relationships. In fact most human relationships of social nature have some aspect of intimacy which may or not lead to sexual interactions of some kind. For People Living with HIV, this is no exception and they are as much entitled to a wholesome sexual and intimate relationship just like any human being. However, intimate relationships where one or more partners involved is HIV positive pose special challenges because HIV brings in special conditions that affect the manner in which sex has to be performed and enjoyed in a relationship. Intimate partners have to modify the manner in which they have they perform sexual acts in order to avoid recontamination, they have to take special care on when to get pregnant and if only one partner is HIV positive care has to be taken so that the other partner is not infected. The reasons above show the intricacy of IPV when it is HIV related.

Because intimacy involves various acts that are mainly sexual in nature, it was not a big surprise that sexual violence was the second most common type of violence that happens in relationships of PLHIV. As a matter of fact 41% of the respondents reported to have suffered sexual violence in the past 12 months while 59% reported that they suffered no sexual abuse. Table 13 below has details.

FIGURE 5: Have you ever suffered any sexual abuse in the last 12 months?



A gender analysis of the victims of sexual IPV reveals that more women proportionally suffered more sexual violence than men. 38% of the women suffered sexual violence against 29% of the men. The reasons for this difference lies in the decision making power in relation to sex that men and women wield in relationship involving PLHIV. This power is exercised in decisions related to usage or not of condoms, who keeps custody and reminds the other partner of HTC instructions that the couple need to follow, who determines the frequency of sex or who decides on the necessity to have another relationship of sexual nature outside the current relationship and what consultations are done before this is executed.

Table 9 below catalogues the most common types of sexual abuse and violence encountered during personal interview amongst PLHIV in the districts of study.

Table 9: Types of sexual abuse suffered by Intimate partners in personal interviews

	Type of Sexual Abuse/ Violence	Frequency	Percentage
Valid	Being forced to have sex without a condom	32	25%
	Total Refusal to have sex with a partners	21	16%
	Proposal to have sex outside relationship	17	13%
	Reduced Sexual activity with a partner	15	12%
	Being forced to have sex when not feeling well	3	2%
	Forced to perform sexual acts without consent	2	2%
	Being refused the right to have a child	1	0.8
	Not Applicable	38	29.5
	Total	**129**	**100.0**

As can be seen above, forcing a partner to have unprotected sex is the most common type of sexual violence amongst partners with HIV. The second common type takes a psychological nature and concerns refusal to have sex with an intimate partner, usually for fear of catching HIV in discordant couples or

because one of the partners insists on sex without a condom. Proposals to have sex outside a relationship are usually made by men.

The gender distribution of the sexual abuses is highlighted in the table 10 below.

TABLE 10: Type of sexual abuse by gender

Types of Sexual Abuses in Intimate Relationship of PLHIV	Gender of Respondent		Total
	Male	Female	
Total Refusal to have sex with partner	9	12	21
Reduced Sexual activity with partner	5	10	15
Proposal to have sex outside relationship	0	17	17
Forced to perform sexual acts without consent	0	2	2
Being forced to have sex without a condom	1	31	32
Being forced to have sex when not feeling well	0	3	3
Being refused the right to have a child	0	1	1
Not Applicable	7	31	38
Total	**22**	**107**	**129**

The table above shows that there are gender dimensions in each type of sexual violence amongst people with HIV that are in intimate relationships. Forcing someone to have sex without a condom, being forced to have sex when not feeling well, proposals to have sex outside a relationship all seem to be sexual abuses perpetrated on women while reduced sexual activity seems to be suffered by both men and women.

Details of each type of sexual violence are provided in greater detail from section 4.4.1 to 4.4.5 below where each type of sexual violence is discussed.

4.4.1 BEING FORCED TO HAVE UN-PROTECTED SEX

Refusal to use a condom or forcing a partner to have unprotected sex is the commonest form of sexual violence in PLHIV. It was reported by 25% of the respondents during personal interviews and is a commonest in married couples. It happens in both concordant and discordant couples. However, it is only when the HIV positive partner is a man that this happens in families since it is technically difficult for a woman to rape a non-willing male. The repercussions of forcing someone to have unprotected sex while one or both partners are HIV positive are dire. Firstly and logically, chances of transmitting the virus to the other partner are high and statistics show that this remains the major way in which HIV is transmitted in Sub-Saharan Africa. Secondly, the victims suffer a lot of psychological torture when they think of the risk of engaging in non protected sex. That is why some partners prefer divorcing or separating from their partners if their partners don't want to use protection.

Anecdotal information acquired during the study suggests that there is widespread unprotected sex amongst PLHIV on ARVs after new emerging information that ARVs reduce the possibility of HIV transmission between sexual partners. That is why discussions with Support Groups in Thyolo, Karonga and Rumphi suggest that pregnancies are on the increase in couples with HIV. The increase is also linked to what is termed as 'decreased economic costs' in raising a baby since new PMTCT guidelines only recommend exclusive breastfeeding for women who are on HIV positive.

It is also such information on lower chances of HIV transmission if you are on ART that some partners are using in order to force the other partner to have unprotected sexual intercourse. When they don't get consent, force is usually used. One quarter of the people interviewed reported being forced to have unprotected sex or simply gave in after persistent demands for 'plain sex' from an intimate partner.

4.4.2 REFUSAL TO USE CONDOMS

Forcing an intimate partner to have sex without protection is usually manifested as refusal to use condoms. This, as has already been said, was catalogued in 25% of the respondents during personal interviews. When a person in an intimate relationship like marriage is found to be HIV positive at an HTC facility, they are advised to use condoms except when they want a partner to become pregnant. However, it is only men that mostly refuse to use condoms. The study reveals that out of the 32 people who reported a partner's refusal to use condoms, 31 were women.

This violence happens due to many factors including ignorance on how HIV is transmitted. Some people feel it is not possible to catch the virus by only engaging in unprotected sex once. Others do it out of malice so that the partner becomes HIV positive as well. This is done because of insecurities by one of the partners that a partner might walk out of a relationship and look for someone who is HIV negative like them. Others generally refuse to use condoms because they feel sex is never enjoyable when done with condoms. That is why statements like 'sweets are never eaten with their package intact' ***(sweet sadyela mpepala)*** are common amongst men. There are also factors related to usage that need proper assessment because discussions in some areas like Ntchisi revealed that people do not consistently use condoms when they have to have several rounds of sex. One female chief actually said that 'you can only use a condom once, the rest of the rounds, it wastes a lot of time putting it on' There are yet others who refuse to use condoms because they are already HIV positive. That is why sentiments like ***'munthu amene wanyowa kale sathawa mvula'*** (you don't seek shelter when you have already been drenched in the rain) However, stories of women that have been forced to accept sex without a condom can be heart rending. In places like Rumphi where one pays dowry in form of a herd of cattle to marry someone, men are usually favoured and given a go ahead to practice unsafe sex even when one of the partners involved is HIV positive. FGDs with women revealed that some chiefs would rule as follows once complaints were lodged by a female partner 'This man paid dowry in form of a herd of cattle in order to enjoy his ***goods***, you don't have to refuse him his rights'

4.4.3 SEX DEPRIVATION

Total deprivation from sex was the second most common form of sexual violence amongst PLHIV, it accounted for 16% of sexual abuses. Partial deprivation of sex happened in 12% of the respondents. Together, they account for 38% of sexual abuse amongst PLHIV, and combined, are the most common form of abuse. Both men and women suffer this kind of violence.

Total refusal mostly happens in discordant couples where a man is HIV positive. This refusal stems from the fear of getting infected even when the HIV positive partner accepts the use of condoms. This refusal usually engenders and enchains other IPV acts such as seeking sex outside marriage. However, the intention of the spouse is mostly to punish their partner but the reactions noted in this study show that this fuels more psychological violence especially against women. Men tend to seek another partner outside marriage as a way of solving this problem, at the same time further undermining collective efforts to manage HIV and AIDS in households because rarely does a partner have influence over what happens in the other relationship.

4.4.4 MARITAL RAPE AND RAPE BETWEEN PARTNERS

Is the kind of violence that mostly occurs when a man is HIV positive and the woman refuses to have sex without a condom. The man would force himself on the woman, mostly for the malicious reason that they should both be HIV+. It happens mostly when a partner, usually a male is drunk or is aggressive due to anger following misunderstandings of diverse nature.

4.4.5 SEEKING ALTERNATIVE SEXUAL RELATIONSHIPS

This abuse was perpetrated by men on women. It was reported in 13% of the respondents in personal interviews and corroborated during FGDs. It is usually a preamble to divorce or polygamy. Male partners who are in a relationship where one of the partners is HIV positive have a tendency of either seeking another partner with a similar sero status. A man for example would ask a female partner that since they are only using condoms, he can have a child with another woman. During FGDs, it was reported that women also ask for permission to find another partner who is HIV negative like her because she would like to have a child and don't want to risk getting HIV. Such issues would come after one or both partners are deprived of sex. If a man is HIV negative, the family or the relationship has very little chance of survival. When it is the other way round, chances of the relationship surviving are greater, especially

amongst women that are financially dependent on their partners. Reasons aimed at preserving the relationship for the sake of children have also been mentioned to save such relationships.

4.5 MAJOR CAUSES OF HIV RELATED INTIMATE PARTNER VIOLENCE

4.5.1 HIV TESTING AND COUNSELLING AS THE MAJOR CAUSE OF IPV

This study retraces its footsteps from the point someone knows they are HIV positive. HTC is the only step one needs to take in order to know they are HIV positive or not. Coincidentally, this study reveals that HTC is also the fulcrum of Intimate Partner Violence. There are many kinds of IPV that have HTC as the major cause, or are exacerbated by being found HIV positive.

Much of the violence happens after only one partner has gone for HTC, especially when an undesirable result is brought to the attention of the other partner. What causes this violence is the failure by the tested partner to properly communicate results to the other, failure by the non-tested partner to understand and accept results as well as the misplaced fear that the couple is going to die due to the long held belief that anyone who catches HIV is going to die sooner than later. In most instances, women feel betrayed when they test HIV positive especially when a man is resisting going for HTC.

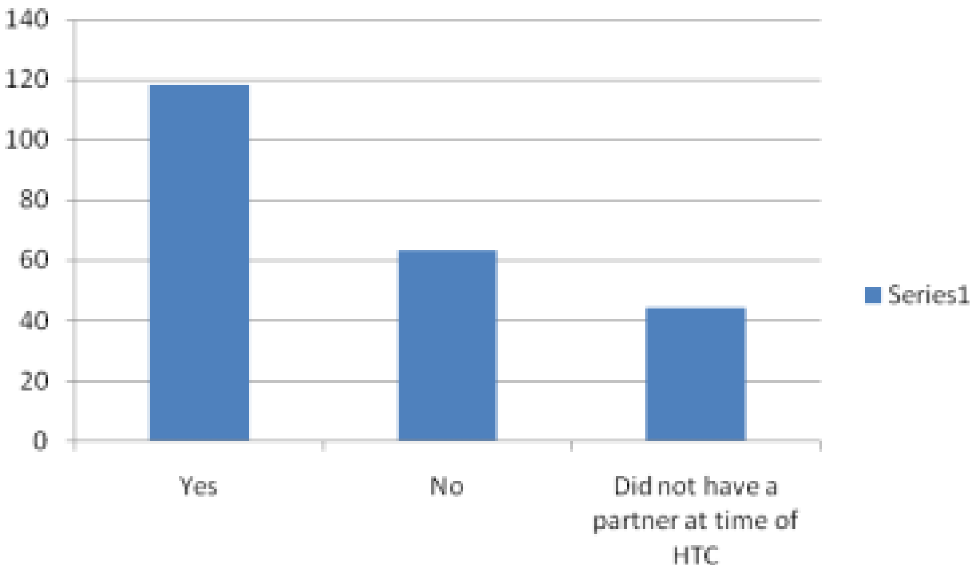
When a partner learns and is shocked by an HIV test result, they come back from HTC fully charged and start announcing orders like '*we will now start using condoms' or 'let's stop having more kids'* without properly explaining what has necessitated that change. This causes friction between partners and causes either physical, sexual and psychological violence. Verbal abuse is highest at this stage, withdrawal from sex and sometimes in areas like Ntchisi, divorce and separation is quite common.

The causes of IPV that originate from HTC are as expanded and highlighted as follows;

4.5.5.1 FAILURE TO PROPERLY COMMUNICATE HTC RESULTS TO A PARTNER

Failure to properly communicate results to the partners who didn't go for the test is one of the major causes of IPV amongst intimate partners with HIV. In some cases, a partner would not wait until the couple is alone to communicate undesirable HIV test results. For example, there have been incidences where women would follow a husband to a bar or drinking joint to accuse him of infecting her with HIV or revealing results in the presence of children at home. The source of this problem is lack of collective action in matters of HIV testing. About 33% of the partners go for HIV testing without their partners and only 52% inform their partners that they are going for an HIV test. The same percentage (52%) inform their new or current partners that they have had an HIV test. Figure 6 and Table 11 show the results.

FIGURE 6: Did you inform partners that you are going for hiv testing



As can be seen above, 28% of the respondents do not inform their partners that they are going for an HIV test. This means that these 28% need to first of all explain reasons that propelled them to go for an HIV test to their partners first before they can reveal the results. This is not an easy task especially when they are found HIV positive. This explains why about 9% of the partners of PLHIV never reveal their HIV test results to their partners as can be seen in table 11 below under section 4.5.1.2.

4.5.1.2 LACK OF DISCLOSURE OF AN INDESIRABLE HTC RESULT TO A PARTNER

Due to the inability to find the right words to tell a partner and fear of negative reactions from a partner after an HIV positive result, 9% of the partners prefer to keep the results to themselves. This in itself is a serious source of sexual violence where actions that can safeguard the other partner cannot be implemented. It also fuels further violence when a partner later finds out about the results. Table 11 below shows more results.

TABLE 11: Did you inform your partner AFTER testing HIV positive

	Response	Frequency	Percentage
Valid	Yes	122	52%
	No	20	9%
	We went together and heard results together	60	26%
	Not Applicable	30	13%
	Total	**232**	**100%**

Failure to inform a partner the results of HTC is also a source of abuse of a partners' rights to know and act according to the sero status of the other partner. In fact 9% of the partners deliberately do not disclose an undesirable HIV result to their intimate partners. During the course of the consultations, we heard a story of two women in a polygamous marriage who had withheld results of an HIV test to their husband. They have been on ART for about a year. These women went for HTC together. The fear for divorce or separation, is one of the most compelling reasons for not telling an HIV positive result to a partner. 32% of the respondents actually feared divorce or separation would follow revelation of an undesirable result to an intimate partner. About 7% feared verbal abuse and another 4% feared that there could be squabbles that could eventually affect their children. Other fears that push people found HIV positive not to disclose results to their partners relate to the negative view a partner may have on their fidelity and sometimes fears on how they are going to coax the partner to undergo HTC themselves. In fact, 33% of the respondents in personal interviews feared that they will have a problem with a partner after an HIV test. Table 12 below shows more details.

TABLE 12: Did you anticipate any problems when you tested HIV+

	Response	Frequency	Percentage
Valid	YES	65	33%
	NO	113	58%
	Not Applicable	17	9%
	Total	**195**	**100.0**

There is also something more interesting to note in table 12 above and table 13 below that not all partners who go for HIV testing together actually hear the results together. In fact 33% of the respondents go for HTC together. However only 26% do it as a couple and hear results together. This means that people actually split to do individual testing and later tell or do not tell each other the results. Therefore, the going together for HTC doesn't have to be interpreted in at face value.

4.5.1.3 LOW PARTICIPATION OF MEN IN HIV TESTING AND COUNSELLING

The low participation of men in HTC fuels IPV because it propels women not to reveal the results of the test, especially when they are undesirable. The low participation also reduces the level of understanding that men have on HIV and AIDS and issues surrounding positive living. In Salima, a woman told a story of a husband who had stayed with her for seven years after she had tested HIV positive but always resisted HIV testing. He later married another woman. In all the districts of study, it has been observed that men do not like going for HTC unless they are very sick. The low participation of men in HTC reduces the overall incidence of couple HIV Testing and Counselling. In fact 56% of the men who were interviewed went with their partner, while as only 27% of the women managed to convince their partner to accompany them for HTC. Table 13 below has details.

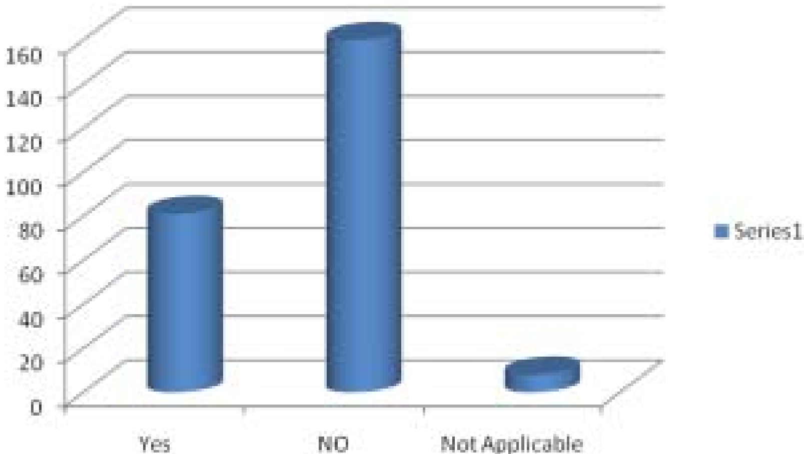
TABLE 13: HIV Testing with Intimate Partners by Gender

	Response	Gender of Respondent		Total
		Male	Female	
HIV Testing with Intimate Partners	Yes	28	53	81
	No	22	138	160
Not Applicable		0	8	8
Total		**50**	**199**	**249**

Not only do men refuse to go for HTC with their partners, some even refuse to go when their partners have been found HIV positive and the health facility has asked that they avail themselves at the facility for Counselling.

Overall, only 33% of the intimate partners go for HTC together while 64% went on their own as can be verified in Figure 7 below.

FIGURE 7: HIV Testing with Intimate Partners



Some of the people who went for HTC with their partners, started by going on their own and invited their partner later after verifying that they are HIV negative. So the reluctance by men might mean several things. Either, they already went for HTC and know their status already, they are afraid of testing or do not see the need for testing and will only do so when they get sick.

Therefore, the low participation especially that of men fuels psychological, physical and sexual abuses since an intimate partner is sometimes forced to withdraw sexual rights because they do not know the other person's status, conflicts that arise from persistent calls by a partner that they need to go for HTC can lead to physical violence. In fact, some women are victimized because they have undergone HTC. Paradoxically it is the one who refuses that usually perpetrates the violence in order to shut the partner or intimidate them against any further calls to go for HTC. This refusal fuels physical, sexual and psychological violence especially verbal abuses, fighting, sex related sanctions and in some cases forced sex of unsafe nature.

4.5.1.4 EXTERNAL PRESSURE FROM RELATIVES AND FRIENDS

There are also external forces that fuel IPV for both unmarried and married couples that prefer to inform their relatives or friends first before they can tell their partner about HIV positive results. In unmarried partners, they would stop seeing their partners without talking through the problem because they have been pressurized by the relatives to leave them. For married couples, friends and relatives often pressurize the partner to leave their partners. The influence of friends is stronger in the urban areas while the influence of family members is stronger in rural area. They go as far as organizing transport to remove their relative from a matrimonial home and words like '*kodi muzikhalabe ndi munthu ofa-ifa' or 'huleyu mukhala naye mpaka liti'* are common amongst couples and their kin.

4.5.1.5 BLAME GAMES ON WHO INFECTED THE OTHER PARTNER WITH HIV

Squabbles also erupt when couples are trying to blame one another for bringing the virus into the household. This leads to lack of cooperation on how to manage the post HIV+ status. Sexual and emotional violence becomes inevitable in such cases because the use of condoms, for example, becomes a problem and sometimes one partner is compelled to seek sexual relief outside the home because of sexual deprivation. In extreme cases, FGDs revealed that some partners even abandon taking ARVs due to such conflicts.

4.5.2 ALCOHOL ABUSE

The abuse of alcohol in one or both couples has been pointed out as one of the key trigger factors for IPV especially physical violence and sexual abuse. Many partners who get drunk physically abuse their partners in their drunken state or deliberately use alcohol as an excuse or smokescreen to mask their already laid plans. Some partners reported that they were either beaten up or forced to have unprotected sex whenever their partners turned up home drunk. In fact 5.7% of the respondents reported that they had caused physical IPV because their partner was drunk. Another 6.2% suffered sexual violence on account of a drunken partner.

4.5.3 INFIDELITY

When at least one of the partners in a relationship is HIV positive, there are so many changes that happen in their sexual life that are necessitated by their status. This doesn't always please both partners such that a partner, usually men, would seek permission or secretly start a relationship outside the current one. In fact 13% of the respondents, largely women, reported that they had suffered the humiliation of a partner expressly or secretly having another sexual relationship outside the current one on account of HIV. When such a relationship starts, the demands in terms of time of the new relationship makes the other partner to suspect that there is something going on outside their relationship. It usually leads to fights, verbal abuse and other sex related sanctions such as refusal to have sex or enforcement of an always use a condom rule. This is done by the victimized partner to protect themselves since they cannot control what happens in the other relationship. However, there are also occasions where partners, mostly women, would drop their insistence on using condoms in order to prevent a partner from continuing an outside relationship.

5.0 CULTURAL PRACTICES THAT FUEL INTIMATE PARTNER VIOLENCE AND HIV AND AIDS

The study also revealed some cultural practices and customs that fuel violations of rights and facilitate IPV. All the customs and cultural practices involve sex without protection. Some of the key ones encountered are highlighted below;

5.1 KULOWA KUFA

When a spouse dies, it is viewed as a sign of bad luck. This bad luck is mitigated by undergoing a sexual cleansing act. The cleansing involves several rounds of sex performed per day by the surviving spouse with an appointed person. No condoms are used regardless of one's HIV status. People do it to avoid being attributed responsibility once there is a recurrence of death in the clan or household.

5.2 BZADE OR KULOWETSA MWANA KUMPHASA

This ritual is performed when a single mum or unmarried girl gets pregnant and delivers a baby. Four to five months after the birth of the child, the Bzade is performed. This is done in order to welcome the child into the village because children born from single mothers are regarded as outcasts. When such children die, their remains are not allowed to spend a night in the village because of fear of bad luck. A man is therefore allocated to perform the bzade act in order to 'remove' bad luck associated with the children. No condoms are used just like in other rituals.

5.3 KUSASA FUMBI

After an initiation ceremony that signifies passage into adulthood 'initiants' are asked to find a partner with whom they should have sex as the final step into adulthood. The parents of the children also stop having sex during the period their child is at the initiation ceremony. To welcome their child into adulthood, they also have to have sex at the break of the initiation. All these sexual acts involve no condoms even where one or both partners have HIV.

5.4 KUPONDELA MOTO, NGOZI OR BWATO

When an accident happens such as a fire or any other accident involving a household member, it is the responsibility of the people involved to organize a ritual to rid their clan of bad luck. This involves having sex without a condom at some appointed time. As a sign that the ritual has been performed, a meal is prepared and served to all people concerned. Likewise, when one has built a canoe, they perform a similar ritual is performed before it is used. This is done to prevent bad luck from happening when using the boat. Again, no condoms are used.

6.0 CONSEQUENCIES OF IPV ON COUPLES, HOUSEHOLDS AND OVERALL HIV/ AIDS MANAGEMENT

HIV related IPV has so many negative consequences on the PLHIV, their partners, households and the overall management of HIV and AIDS in the country. Due to the physical, psychological and sexual strain that IPV puts of the victims, there are dangers that provide challenges in overall HIV management. Some of the consequences of IPV that were captured during the study are as follows:

6.1 REFUSAL TO CONTINUE ART

Circumstances that cause frustrations from partners' cause some people to stop taking ARVs. Emotional PLHIV that are on ART are sometimes incapable of standing pressures of seeing a partner refuse them conjugal rights, spend a lot of time with a 'rival' partner or any of the sanctions that comes with disagreements related to one's HIV status. As a result of this, some PLHIV that are on ART, particularly women prefer to stop ART so that they force the partner feel pity of them or just to cut short their life by further deteriorating their health. Stand alone partners have greater capacity to destroy themselves in such a manner than those in Support Groups who utilize the group therapies to deal with or at least attenuate the pressures of IPV.

6.2 INCONSISTENCY IN FOLLOWING ART GUIDELINES

Non disclosure of one's HIV positive sero status to an intimate partner forces the partner to do certain things against the advice they receive at HTC or PMTCT. For example, one woman cheated her husband that she was taking family planning pills while it was ARVs she was taking and others reach the extent of taking ARVs in hiding or at a friend's place. Such behavior prevents people from being consistent in following ART guidelines because they may not always have time to go and take ARVs from the neighbors or friends place if the partner is with them. If someone is advised to use condoms and they don't tell their partner about their status, the other partner may unknowingly be enjoying unprotected sex and unknowingly expose him or herself to HIV infection. At the same time, his or her partner on ART will be adulterating the instructions given at HTC and ART. Due to this, there is lack of consistency in following ART guidelines.

6.3 POOR MANAGEMENT OF OPPORTUNISTIC INFECTIONS (OIs)

Proper management of OIs is a quality factor that defines a wholesome ART regime. As has already been highlighted in above sections, failure to consistently use condoms, failure to have adequate supplies of CPT because a partner is hiding HIV status from a partner can lead to inconsistencies in use of CPT and other medication that prevents or manages the emergence of OIs. With the widespread shortage of CPT in government health facilities, partners who are financially dependent on a partner may have problems purchasing CPT because they are under economic sanctions or separated from an intimate partner.

6.4 UNPLANNED PREGNANCIES

Due to fears of violence or abuse in an intimate relationship involving one or more partners with HIV, things like refusal to use condoms, marital rape or forced sex as well as fear to tell a partner your HIV status can lead to unplanned pregnancies. While getting pregnant is not in its own a problem, but women with HIV need to have the right physical strength to do so. If it happens every year, this may further damage the health of the mother and compromise the care for the children.

6.5 POOR MANAGEMENT OF THE HOUSEHOLD AND SELF

Poor management of Opportunistic Infection (OIs) due to secrecy, erratic use of ARVs and other medication, displacement of a partner from a home due to separation or divorce takes away one's concentration

from managing their personal health. This equally reduces the way someone can properly manage the household where vulnerable members like children can suffer consequences.

6.6 PROMISCUOUS BEHAVIOR

Testimonies from Support Groups indicate partnerships where one or both partners are HIV positive and are not agreeing on use of condoms show that some partners who prefer sex without condoms are sometimes forced to seek sexual partnerships outside marriage. This sometimes spills into seeking sex with sex workers because other members of the immediate community may be aware of his or her status. This promiscuous behavior is dangerous and makes cross-fertilization of HIV strains.

7.0 MECHANISMS IN PLACE FOR RESOLVING INTIMATE PARTNER VIOLENCE INVOLVING PLHIV

Before looking at what is on the ground in terms of structures and systems for preventing, managing and mitigating the impacts of HIV related IPV, it is important to consider the HIV/AIDS legal framework and how ably it supports management of IPV at health provider facility and sub-facility levels. The HIV and AIDS policy of Malawi recognizes the following:

a. It recognizes HIV testing as a problem in Malawi because, as of 2003, less than 3% of the adult population had not known their HIV sero status. As a result, HTC is regarded as an essential component on the continuum of HIV treatment, care and support for PLHIV. The policy guidelines are designed to motivate someone who is found HIV positive towards positive behavior change. Issues of transmission and re-transmission are also well articulated in the policy.

b. It also recognizes stigma and discrimination towards people that have opted to live positively with HIV

c. It recognizes the woman's face of HIV due to the inequitable power relations between men and women, and young girls in particular. It further alludes to the fact that the unequal position of girls and women in society and the fact that, due to their biological, social, cultural and economic factors, they are more likely to be infected and adversely affected by HIV than men.

d. The policy recognizes cultural and religious factors influence on HIV and AIDS, its governance and poverty as well as lifestyle choices.

e. It further recognizes that an effective response to HIV requires respect for protection and fulfillment of all human rights and upholding the fundamental freedoms of all people, in accordance with the constitution of Malawi and existing international human rights principles, norms and standards.

f. Finally, the policy recognizes the protection, participation and empowerment of PLHIV, vulnerable populations such as women, girls, orphans, young people, widows and widowers, the poor, those engaged in transactional sex, people with disabilities, people involved in same sex sexual relationships and mobile populations.

However, looking at the policy translation at health facility and community levels, leaves a lot to be desired. There is very little in terms of protection of vulnerable women and other groups, especially from psychological and sexual abuses, local justice systems based on traditional leadership are not only prepared but not adequately capacitated to handle IPV as a key component of HIV. Cultural practices that make women and young people vulnerable continue to be just timidly challenged due to lack of political championship to curb such practices and discrimination of PLHIV amongst intimate partners continue to be the order of the day.

It was therefore, not a surprise to identify only three key institutions that are involved in resolution of conflicts that arise from abuses amongst partners with HIV. These are:

a) Local leaders (Village Heads, Group Village Heads or higher)

b) Community and Police Victim Support Units

c) Religious Institutions, particularly churches

d) Courts

Malawi being a predominantly rural economy where the chief is the first authority one can easily get in contact with, chiefs remain one of the key actors in resolving IPV involving HIV positive partners. The church is the commonest point of contact for IPV resolution amongst the religious institutions. Victim Support Units (VSUs) also play a critical role. The courts are actually employed more when all efforts to resolve the conflicts have failed and the partners are seeking divorce or separation.

7.1 ROLE OF LOCAL LEADERS IN RESOLUTION OF HIV RELATED INTIMATE PARTNER VIOLENCE

Local leaders have traditionally played a very critical role in conflict resolution in all areas of Malawi. They are also a key point of recourse especially in rural areas. Their roles have been and are still very well appreciated in resolution of IPV that involves physical violence and psychological abuse that is verbal. This is so because, it is easy to get evidence that someone was physically or verbally abused. However, chiefs seem to be ill-prepared for sexual and much of the psychological violence. This is so because it is difficult to get evidence or testimonies for this kind of abuse. In fact only 27.2% of the respondents reported their psychologically abuse to anyone. 17.3% of the respondents never reported any sexual violence. There is no clear pattern as to which is the preferred institution or person where this is reported. In addition, FGDs and testimonies from the chiefs themselves confirm that they are also ill prepared to handle HIV related conflicts. The majority of the chiefs have never gone for HTC, neither have they been trained in HIV particularly on major forms of IPV and how they can be viewed with an HIV eye. As a result of this, so many erratic decisions and comments are made that do not help champion the cause of HIV neither does their approach ensure fairness for HIV related IPV. For example, it is on record that in Thyolo, most chiefs would go behind the backs of PLHIV to advise a person with unknown HIV status (or one who is HIV negative) to just forgive the person with HIV in conflict because he or she is psychologically affected by the ARVs he or she takes ***(muziwakhululukira awa. Mankhwala amene amamwawa amawazunguzunza mutu)*** or more dangerously a Rumphi Chief that ruled that a woman with HIV doesn't need to prevent her man from having sex without condoms because the man paid for his 'goods' using dowry ***(osamamukaniza mamunayo chifukwa zinthuzi ndizake ndipo analipilapo ng'ombe)*** These examples signify the lack of preparedness, knowledge and information by chiefs to properly resolve issues of this kind. Those that were met in FGDs admitted this lack of knowledge and tact in handling HIV related IPV. That is why most incidences especially those involving psychological violence or sexual abuse in intimate partnerships involving PLHIV remain unreported to this institution.

Focus Group Discussions also revealed further problems that affect fairness and the confidentiality with which the issues related to IPV are handled at local leaders. It was pointed out that the chiefs places are public domains that are not convenient enough to handle sensitive issues like HIV related IPV. That is why most people don't even bother report to local leaders once such intimate cases happen.

7.2 RELIGIOUS INSTITUTIONS

Many Malawians belong to a religion of some kind and religions are a symbol of fairness and impartiality. Churches were seen to play a more prominent role in most areas. Even though churches help a great deal in resolving IPV amongst PLHIV, they face preparedness challenges like chiefs and also have problems of uniting people of different faiths. Religion, however, plays an important psychological aspect in management of IPV through provision of soulful fortitude to the partners involved.

7.3 VICTIM SUPPORT UNITS

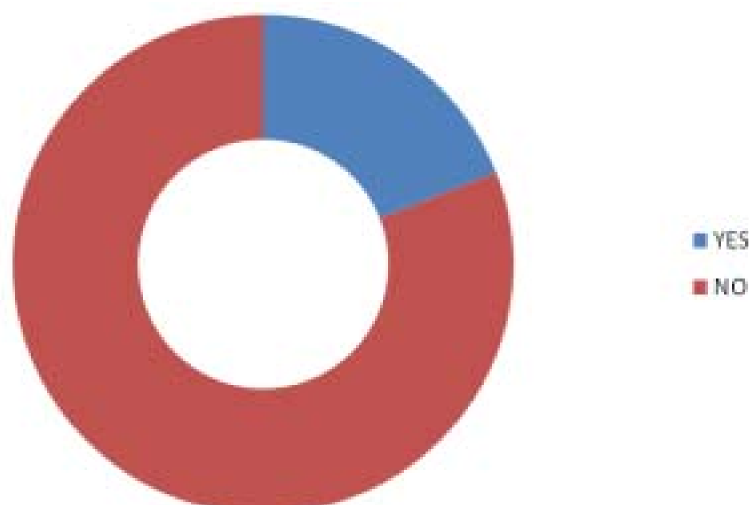
In order to properly understand the Victim Support Units (VSUs) and how they are used as an avenue for mediating between partners involved in IPV, a study of key cases that go through the Police VSU was conducted. The observations and study of records of cases handled through PVSUs and cases that went through Courts reveals that maltreatment of a partner (mostly a female partner), assaults, failure to render assistance to a partner and one's children, desertions and property grabbing are the major cases reported and resolved through courts. Table 21 below shows the major cases observed:

TABLE 14: Major Cases reported in police Victim Support Units and Handled in Courts				
	Number of Cases per District in 2011			
Nature and Description of Case	**Salima VSU**	**Ntchisi VSU**	**Thyolo VSU**	**Thyolo Magistrate Court**
Maltreatment of partner or household member	-	49		
Failure to render assistance to wife and children	63	36	39	38
Wife Battery and Assaults	9	25	46	58
HIV related IPV	-	-	-	-
Deserting (a wife)	45		31	26
Property grabbing			29	11

As can be seen in table 14 above, there are no cases you can specifically term as IPV and HIV related. This is so because there is no systematic recording of IPV-HIV related cases in their own category. Discussions with Officers responsible for VSU activity shows that there are some cases that can be termed HIV related IPV. In fact, in Salima we interviewed some women at the VSU that had been assaulted by their partners and had visible signs of some serious assault with objects and hands. The origins of the assault was HIV related. In this era, where many stakeholders are working so hard to fight HIV and AIDS and its impacts, it is a necessity that such cases are well classified and for purposes of learning, follow up and future decision making and programming.

Personal interviews during the study revealed that out of 205 people with whom the issue of VSUs was discussed, only 19% had ever reported any IPV to the Police or community VSU as can be seen in Figure 8 below;

FIGURE 8: Have you ever reported any HIV related violence to a VSU?



81% of the people with HIV have never reported anything to the VSU even on behalf of someone else nor have they been involved in any case to merit their use of a VSU. In fact a lot of people expessed ignorance about VSUs. Discussions with PLHIV belonging to support groups also revealed some information that show the functionality of VSUs. These are outlined as follows:

a. There is great dissatisfaction with the way HIV related IPV cases are handled in VSUs due to the dominating environment at the VSUs. The VSUs generally lack confidentiality as Victims or complainants of IPV are treated and welcomed as people who have come with criminal of civil cases.

b. There is a general lack of courtesy in the manner in which IPV victims are welcomed at the VSUs. Some PLHIV testified to being interviewed in full view of everyone present. This puts off complainants from giving their full account of intimate events that may have happened and affected their life;

c. PLHIV in most focus groups reported a general lack of professionalism by Officers that manage VSUs. They do not concentrate on what the victims are reporting and can have some parallel chat sessions with workmates on going while recording a complainants' statement. Even where an officers' conduct is professional, interruptions from other officers who come just to 'poke their noses' into what is being said are a constant irritation to the complainants of IPV cases. These complaints were strong in Karonga. Incidents of shouting at complainants or intimidating them were also reported.

d. In some VSUs like at Ntchisi, Officers at VSUs are blamed for being immature, lacking seriousness and always rushing to suggest steps to dissolve partnerships. The blame of VSU for rushing to help partners dissolve partnerships was talked about in most districts. In fact, when someone comes to the VSU for the second time, officers usually say ***'kodi mwabweranso sizikusintha'(so you are here again)*** When the response is in the affirmative, they are advised to go to courts to have the relationship dissolved without critical review of the case. This has been attributed to allocation of young officers with no marriage or life experience who cannot take a mature stand on issues due to their lack of appreciation of marriage in particular.

e. VSUs were blamed for failure to provide any meaningful advice to IPV complainants. In most cases, partners were being asked to go back and discuss the issues over again. Further advice is that if they don't agree, they should just go to court.

f. Concerns of bribery and favouritism are also common at Police VSUs where wealthy people are said to be favoured. These complaints were very strong in Thyolo where files of poor complainants mysteriously get lost or have their hearings adjourned at court every now and then to demoralize them.

g. Police deliberately intimidate complainants to induce them to pay bribes

Further inquiry on whether there is some monitoring of progress of people that receive counsel showed that the only follow up done by Police VSUs relies on the victims or the counseled themselves coming back to inform the VSU if there have been changes as advised or when they further come to complain that the abuse is still ongoing. At this point, they ask the complaint to be taken to the courts where relationships are mostly dissolved.

8.0 CONCLUSIONS AND RECOMMENDATIONS

This study confirms the occurrence of HIV related Intimate Partner Violence in all the six districts of study. Psychological and sexual violence are more common than physical violence. While there is a lot of comfort in reporting physical violence, there is a lot of lacuna in reporting psychological and sexual violence because psychological violence doesn't get much attention in our evidence based resolution mechanisms. At the VSUs or local chiefs, there is emphasis on bringing evidence that something happened which most of the PLHIV have problems to bring. Sexual violence usually happens in the intimacy of the homes and sex is largely regarded too taboo a subject to be discussed with anyone. The problems of confidentiality at the local chiefs and VSUs also deter a lot of victims to report sexual abuses that happen in their households.

Low levels of male involvement and willingness to undergo HTC with their female intimate partners is also one of the major factors that trigger violence amongst intimate partners with HIV. Women have more avenues to be tested especially with the integration of PMTCT with ANC. In the same vein, men, just like people with higher education, in white collar jobs, and young people and unmarried PLHIV who are less than 25 years old are likely to be difficult to reach with IPV interventions if the Support group has been used as an entry point like most of the interventions especially by NGOs.

Men remain the major perpetrators of all types of violence and abuse while women remain by far the major victims. Women remain key perpetrators when it comes to verbal abuse, applying sexual sanctions and withholding food from a partner. This shows the levels of control women have over food and to some extent, some control over sexual activity in a relationship for short periods of times. However, assertions of this control further triggers marital rape or being forced to have unprotected sex. The high incidence of verbal abuse by women against men points to the fact that low levels of education and low knowledge of rights might be key factors that fuel verbal abuse. Assertions that most people are not aware of what constitutes IPV back this claim.

There is also evidence that someone's HIV positive status seems to increase their likelihood of committing or suffering from IPV. This is due to an increase in trigger factors such as improper communication of results and Counselling tips to non tested partner, discovery that partner is HIV positive or is on ART, intimacy behavioural changes such as usage of condoms and its ensuing resistance, denial of undesirable HIV status, squabbles on child bearing and its frequency, cultural pressures and pressure from other family members. That is why there seems to be an increase in violence when someone has just undergone an HIV test or has disclosed his or her HIV status to the community. Therefore, it can be said that there is a strong link between HIV status and IPV.

IPV resolution mechanisms seem to be uncoordinated, lack capacity, resources, manpower, will power and zeal to properly handle such cases. In fact, there are many barriers that prevent or deter PLHIV from using some redress mechanisms in place. Firstly, VSUs at community level are largely manned by volunteers and are closed at night, yet much violence happens at this time. Secondly chiefs lack training and preparedness to tackle sexual and psychological violence. Thirdly community VSU are greatly constrained in human resources and resources while Police VSU have attitude problems and lastly lack proper infrastructure and have no coherent system for monitoring IPV.

There are also cultural systems and acts that further fuel IPV and make the fight against HIV in Malawi a big challenge. These cultures reduce the efficacy of ART programmes and makes the management of OIs a big challenge due the emphasis on unprotected sex, in order to perform the rituals. Likewise, there is some cultural tolerance by society of IPV especially the types perpetrated against women. The story of a Rumphi woman who was ordered by a local chief to drop the use of condoms because her spouse paid dowry to have her is such an example.

There is also poor translation of the HIV policy into actions that can curb IPV amongst PLHIV at health facility and other lower levels.

It is from the above observations that the following recommendations are being made so that efforts to reduce HIV related IPV are sustained:

a) There is need for economic empowerment of vulnerable women living with HIV, who remain the biggest victims of HIV related IPV. This will ensure that they have ability to make choices on staying on or not in an abusive relationship and not just being forced by their economic dependency on the male partner as has been the case;

b) COWLHA needs to advocate for the popularization of Post-Exposure Prophylaxis (PEP) as a remedy for abuses related to marital rape, exposure to HIV infection amongst discordant partners due to non use of condoms or amongst people with unknown HIV status.

c) There is need to clarify on whether HIV testing is compulsory at ANC following the integration of PMTCT with ANC, neither is there any clarity on male partner involvement. The lack of male involvement has far reaching consequences on IPV and need to be enforced in one way or the other.

d) COWLHA needs to start a serious campaign to inform PLHIV and the general public on the various forms and nature of IPV as well as low knowledge of rights of PLHIV amongst intimate partners. This will ensure that there is knowledge on various abuses and potentially, a reduction of verbal abuse largely perpetrated against men whose origin seems to be inadequate knowledge about upholding rights of an intimate partner.

e) The capacity building of local leaders, marriage counselors and religious leaders in resolution of IPV as well as provision of information to these institutions on HTC, HIV and other related issues will help improve the manner in which IPV is handled at these levels. This must be taken as a priority.

f) There is also an urgent need to change the manner in which Counselling is provided to discordant and concordant couples to add aspects of 'disclosure of results to partners' especially those that are not willing to attend HTC. In addition, discordant couples require continued periodic comprehensive Counselling in order to manage the post HIV+ era.

g) There is need for COWLHA to advocate for door-to-door approaches in Counselling amongst the NGO folk in order to complement government efforts in providing static HTC centres. This will enhance male involvement in HTC and reduce trauma and squabbles that lead to IPV.

h) There is need for government health facilities to adopt the male championship model to boost male involvement in HTC, ART, PMTCT and SRH issues. The model can be based on the Mwanza or Mchinji Model which has strong community ownership.

i) For IPV victims to properly report cases, there is urgent need to popularize the use of Community and Police VSU as well as take measures to improve their confidentiality and follow up mechanisms on complaints lodged at these institutions.

j) Any interventions on IPV amongst PLHIV that uses the Support Group as an entry point is going to miss out on PHIV with higher education, young people and couples below 25 years and a great number of men. Therefore, IPV interventions need to have the considerations of these dynamics in the design of such interventions.

GLOSSARY OF TERMS USED IN GENDER AND INTIMATE PARTNER VIOLENCE

GENDER Refers to the social difference between males and females throughout the life cycle that are learned and though deeply rooted in every culture are changeable over time and have wide variations both within and between cultures. Gender along with class and race determine the role, power and resources for females and males in any culture.

GENDER ANALYSIS is the systematic way of looking at different impacts of development, policies, programmes and legislation on women and men that entails collecting sex disaggregated data and gender sensitive information about the population concerned.

GENDER EQUALITY Equality between men and women refers to the equal enjoyment by women and men of rights opportunities, resources and rewards.

GENDER BASED VIOLENCE is the term that embraces a range of concepts that incorporate an analysis of gender equality as the root cause of GBV. Essentially, it means any act that results in or is likely to result in physical, economical, sexual or psychological harm of suffering including threats of such acts, coercion, arbitrary deprivation of liberty whether occurring in public or private life. It can encompass sexual violence, domestic violence, sex trafficking, harmful practices such as female genital mutilation, forced or early marriage, forced prostitution, sexual harassment and sexual exploitation etc.

INTIMATE PARTNER VIOLENCE (IPV) Describes physical, sexual or psychological harm by a current or former partner or spouse. It can occur in heterosexual or same sex couples and doesn't require sexual intimacy.

SEX Describes the biological difference between men and women, which are universal and determined at birth.

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