Intimate partner violence as an obstacle to safer sex practice in South Africa

by

Catherine Ajibola Ogunmefun

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Abstract

Intimate partner violence is one of the major forms of violence against women, and it contributes to the inability of women to practice safer sex. This study uses a triangulation method to explore the relationship between intimate partner violence and condom use. Secondary data was used for both the quantitative and qualitative analyses. The results from both the quantitative and qualitative analyses revealed that women who report intimate partner violence are less likely to use condom. Other results from the quantitative analysis revealed that women with high socio-economic status are more likely to use condom. However, the qualitative analysis revealed that women experience intimate partner violence irrespective of their socio-economic status. Nevertheless, the two analyses revealed that a woman is less likely to use condom if her partner dislikes it. Moreover, negotiating for condom use could lead to further violence. As a result of this, there is need to target both men and women when addressing the issues of intimate partner violence and safer sex practice.

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Declaration

This dissertation represents the original work of the author and it has never been submitted before for any degree or examination in any University. Full acknowledgment is given for all the sources referred to in this thesis.

CONTENTS

Chapter 1: Introduction	1
1.1 Introduction	1
1.2 What is Intimate Partner Violence (IPV)?	2
1.3 Global magnitude of intimate partner violence	2
1.4 Consequences of intimate partner violence	5
1.5 Purpose of the study	7
1.6 Hypotheses and Research Questions	8
1.7 Assumptions and Limitations	9
1.8 Data sources and Methods	9
Chapter 2: Literature Review	11
2.1 Factors enhancing Intimate Partner Violence (IPV)	12
2.2 Forms of intimate partner violence	19
2.3 Consequences of intimate partner violence	19
Chapter 3: Conceptual and theoretical Framework	23
3.1 Patriarchal Theory	23
Chapter 4: Methodology	30
4.1 Data and Variables	30
4.2 Methods	32
Chapter 5: Intimate partner violence (IPV) and condom use	35
5.1 Intimate partner violence	35
5.2 Types of IPV reported	36
5.3 Socio-demographic characteristics of the women	36
5.4 Condom use	39
5.4.1 Socio-demographic characteristics and condom use	39
5.5 Results of logistic regression model of socio-demographic variables	42
5.6 Sexual behaviour	43
5.6.1 Sexual behaviour and condom use	45
5.7 Results of the logistic regression model of sexual behaviour	47
5.8 Partner's background characteristics	47
5.9 Results of the logistic regression model of partner's characteristics	48
5.10 The relationship between IPV and condom use	50
5.11 Discussion of major findings	50
Chapter 6: Analysis of case studies of women that experienced IPV	54
6.1 Main case study	54
6.2 Discussion	59

Chapter 7: Conclusion and recommendations 62
7.1 Summary of major findings from triangulation method 62
7.2 Recommendations 63

Bibliography 67

List of tables

5.1 Intimate partner violence	35
5.2 Types of intimate partner violence	36
5.3 Socio-demographic characteristics	37
5.4: Condom use by socio-demographic characteristics	40
5.5: Logistic regression model of socio-demographic variables	42
5. 6: Sexual behaviour variables	44
5. 6b: Sexual behaviour and use of condom	46
5. 7: Logistic regression model of sexual behaviour	47
5. 8: Partner's background characteristics	48
5.9: Logistic regression model of partner's characteristics	49
5.10: Bivariate logistic regression of IPV and condom use	50

List of Figures

3.1 Inter- relationship between patriarchy, intimate partner violence and unsafe sex practice 28
5.1 Condom use 39

Chapter One

Introduction

1.1 Introduction

Violence, in various forms, could be considered as part and parcel of life for many women around the globe. Not only do they experience it outside their homes but also in private, sometimes perpetrated by those considered to be loved ones. The World Health Organisation (WHO) (2002) reports "at least one in five of the world's female population has been physically or sexually abused by a man or men at some time in their life".

The term 'violence against women' refers to the various forms of harmful behaviour directed at women and girls as a result of their sex (Population Reports, 2002). These various forms of violence experienced by females from infancy to old age, range from female infanticide, child marriage, incest, child prostitution and pornography, dating and courtship violence, partner violence, marital rape, dowry abuse and murders, to forced 'suicide' or homicide of widows for economic reasons, as well as physical, sexual and psychological abuse (Population Reports, 2002).

In order to take into consideration all these various forms of violence against women, in 1993, the United Nations General Assembly offered the first definition of this kind of violence when it adopted the Declaration on the Elimination of Violence Against Women. This UN Declaration defines violence against women as,

> "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" (WHO, 2002).

This definition goes on to distinguish between physical, sexual and psychological violence within the family and in the community as that which

- takes place in the family, including battering; sexual abuse of female children in the household; dowry related violence; marital rape; female genital mutilation and other traditional practices harmful to women; non-spousal violence; and violence related to exploitation;
- occurs within the general community, including rape; sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women and forced prostitution;

- and that is perpetrated or condoned by the state wherever it occurs (Gordon and Crehan, 2002).

This definition shows that 'violence against women' is a broad term that encompasses a wide range of violence against females. One of the most common forms of violence against women is intimate partner violence (Population Reports, 2002). Intimate partner violence is also known as 'wife beating/battering', 'domestic violence', 'dating violence' and 'partner abuse' (Population Reports, 2002; Moore, 1999:302). The focus of this study is however on intimate partner abuse.

1.2 What is Intimate Partner Violence (IPV)?

In this study, intimate partner violence would be defined as any form of violence or abuse that is perpetrated by a male partner against his intimate female partner, that could result in physical, sexual, emotional and financial suffering – (or harm) on the part of the woman. Intimate partner violence includes various forms of violence such as kicking, slapping and throwing an object at a partner, sexual assault, stalking, psychological abuse, intimidation and the deprivation of key resources such as food, clothing, money, transportation or health care, etc (Moore, 1999: 302).

There are four main forms of violence that shall be examined in this study, and these are as follows:

- *Physical abuse/violence* includes slaps, punches, kicks, assaults with a weapon, and homicide.
- *Sexual abuse/violence* includes forced sex and forced participation in degrading sexual acts.
- *Psychological/emotional abuse* includes prohibiting a woman from seeing her family and friends, belittlement or humiliation.
- *Economic abuse* includes not providing money for maintenance of the family even though the man can afford it, preventing a woman from working and confiscating her earnings (Watts and Zimmerman, 2002:1233).

1.3 Global Magnitude of Intimate Partner Violence

Even though many studies have been conducted on intimate partner violence all over the world, it has been very difficult to know the actual magnitude of the problem. This is because many women do not report the violence committed against

them by their partners due to shame. And when it is reported the law is more on the side of the perpetrator than that of the victim. Watts and Zimmerman (2002:1232) also concur with the fact that violence against women is almost universally under-reported because of the sensitivity of the subject. It is therefore good to keep in mind that the magnitude of intimate partner violence is much more than what has been reported by studies conducted on the subject. The following are the reports of some of the studies conducted all over the world, showing the incidence of intimate partner violence.

North America and Europe

- Canada (1993) - in a nationally representative sample of 12,300 women aged 18 years and older, 29% reported that they have been physically assaulted by a current or former partner since the age of 16
- United States (1986) – 28% of women reported at least one episode of physical violence from their partner in their lifetime in a nationally representative sample of married or cohabiting couples
- Switzerland (1994-96) - a study revealed that 21% of women 1500 aged 20-60 years had been physically assaulted at some time by a partner
- United Kingdom (1995) - in a random sample of women in the London Borough of Islington, 255 of them had been punched or slapped by a partner or ex-partner in their lifetime

Asia and the Pacific

- Cambodia (1996) – in a nationally representative sample of women and men aged 15-49, 16% of women reported being physically abused by a spouse while 8% reported being injured
- India (1999) – 40% of 9938 women in six states aged 15-49 years reported physical abuse by partner
- Korea (1992) – in a stratified random sample of entire country, 38% of wives reported being physically abused by their spouse in the last year
- Malaysia (1992) – in a national random sample of Peninsular Malaysia, 39% of 713 women over 15 years reported being beaten by a partner

Africa

- Egypt (1995-96) – in a study, 34% of 7121 women aged 15-49 years had been physically abused at some time by partner.

- Zimbabwe (1996)- in a representative sample of 966 women over 18 years in Midlands province, 17% reported physical assault by partner
- Zambia (1992) - in a sample of 171 women aged 20-40 years, 40% reported being beaten by a partner and another 40% reported mental abuse; 17% considered physical or mental abuse a normal part of marriage
- Uganda (1997) – in a representative sample of women aged 20-44 and their partners in two districts, Masaka and Lira, 41% of women reported being beaten or physically harmed by a partner; 41% of men reported beating their partner

Latin America and the Caribbean

- Chile (1993)- in a stratified random sample of 1000 women in Santiago aged 22-55 years involved in a relationship of 2 years or more, 60% had been abused by an intimate male partner
- Nicaragua (1996) - in a representative sample of ever-married women aged 15-49, from Leon (Nicaragua's second largest city), 52% reported being physically abused by a partner at least once.
- Mexico (1997) – in a representative sample of 650 ever married /partnered women, 15 years or older from Metropolitan Guadalajara, 30% reported at least one episode of physical violence by a partner
- Colombia (1995) – in nationally representative sample of 6,097 women in a relationship, aged 15-49, 19% had been physically assaulted by their partner in their lifetime.

(WHO, 2002; Watts and Zimmerman, 2002:1234; Heise et al., 1994: 1166)

These global statistics show the global magnitude of intimate partner violence, however as aforementioned it is difficult to get the real or full picture due to under-reporting. It could also be observed that most of the studies focused more on physical abuse. However, intimate partner violence is much more than physical abuse. The main reason is that it is easier for physical abuse to be measured than other forms of abuse especially when it comes to emotional abuse, which could not be seen. Hence the need for more studies that not only focus on physical abuse but also sexual, emotional and economical/ financial abuse. This present study would be taking these four forms of intimate partner violence/abuse into consideration. The

next to be considered are the consequences of these four forms of intimate partner violence.

1.4 Consequences of Intimate Partner Violence

Intimate partner violence is known to have negative consequences on women that have experienced it. Sometimes it could cause an inter-generationational repercussion, as this violence would pass unto coming generations. Girls who witnessed their mothers being beaten by their fathers would learn to condone or accommodate intimate partner violence when they become women while boys would learn to use violence to settle problems when they are older. Thereby contributing to a cycle of violence (WHO, 2002).

According to WHO (2002), the consequences of violence against women may either be fatal or non-fatal. The non-fatal consequences are in form of physical injuries which range from minor cuts and bruises to chronic disability, or mental health problems. The fatal consequences include intentional homicide, death as a result of injuries sustained, STIs (including HIV/AIDS) transmission, and suicide.These and some other consequences would next be examined in detail.

Injuries

Women who are in abusive (intimate) relationship are usually beaten and this might make them to sustain injuries that range from bruises and fractures to chronic disabilities. A study in Papua New Guinea revealed that 18% of all urban married women had to seek hospital treatment following intimate partner violence (WHO, 2002). Most abused women are commonly injured in the head, face, neck, breasts or abdomen (Moore, 1999). Moore cites the example of a study that notes that the breasts and upper extremities may frequently be injured when women attempt to defend or protect themselves. Some other physical injuries she mentioned include black eyes, lacerations, contusions, bite and knife wounds, joint damage, fractures, burns, concussions and loss of hearing or vision (Moore, 1999: 303).

Even though these injuries sustained by women in abusive (intimate) relationship could be considered to be fatal, it could even be more serious if the woman in question is pregnant. According to WHO (2002), recent research has identified violence during pregnancy as a risk to the health of mothers and unborn babies. One study revealed that 1203 pregnant women in hospitals in Houston and

Boston, United States, who reported abuse during pregnancy had a significant risk factor for low birth weight, low maternal weight gain, infections and anaemia (WHO, 2002).

Unwanted pregnancy

Unintended pregnancy is another consequence of intimate partner violence. Women in abusive relationship are either forced to have sex with their partners or they may not be able to negotiate safer sex practice with them. For instance, some women might be afraid to raise the issue of contraception with their partners because of the fear of being beaten or abandoned (WHO, 2002). The chance of a woman being abused in an intimate relationship might even be higher where it is believed that the primary role of a woman is bearing of children, this therefore makes a woman who believed otherwise to be in the danger of intimate partner violence.

Moore (1999:304) posits that unintended pregnancy may either result directly from sexual abuse, due to the inability of women to negotiate contraception, or indirectly, as abused women may be more likely than other women to engage in risky sexual behaviour. She also points out that unintended conception may be a risk factor for violence during pregnancy. She cites an example of a study that revealed that almost 70% of women with unwanted and mistimed pregnancies reported physical violence during pregnancy (Moore, 1999). One reason that could be given for this is that violence might occur in a relationship if the couple have a low income. This is because the man might not want a child (if he thinks he cannot afford it) thereby giving vent to his anger by beating the woman.

Birth Outcomes

Even though it is always the woman that bears the brunt of intimate partner violence in most cases, sometimes her child might also be affected if the woman was abused when pregnant. According to Moore (1999: 304), there are many ways in which violence during pregnancy could be related to development of poor health or injury for the infant. Physical violence or a blow to the abdomen (of the woman) might put the foetus at risk. Also elevated stress levels, delay in seeking prenatal care, poor nutrition or substance which could be caused by intimate partner violence might indirectly lead to poor birth outcomes such as low birth weight or preterm delivery (Moore, 1999).

Moore also states that several studies have found more direct associations between abuse during pregnancy and preterm labour, caesarean delivery, low birth

weight and miscarriages (1999). This shows that there is more cause to be alarmed about intimate partner violence, since the unborn baby is also in danger of suffering if a pregnant woman is being abused in an intimate relationship.

STIs including HIV transmission

As with unwanted pregnancy, it is easy for women to contract STIs including HIV/AIDS not only because they are biologically more susceptible, but also as a result of their inability to negotiate safer sex practice in an abusive relationship (WHO, 2002). In fact, one of the reasons why intimate partner violence is under spotlight is because violence makes women to be more vulnerable to STIs including the dreaded HIV, which has killed millions all over the world. As at the end of 2001, 40 million adults and children have been infected with HIV, majority of which are in sub-Saharan Africa (UNAIDS, 2002). According to Gelmon and Piot (1996:99), persons who have histories of STIs are at greater risk of contracting HIV and also HIV-infected persons are likely to have a greater susceptibility to infection with other STIs. And since intimate partner violence might aggravate the connection between the two (due to inability of women to negotiate safer sex), there is a need to address the problem of IPV.

According to Moore (1999:304)," women who are infected with HIV, or who are considered to be at high risk for HIV infection, report high rates of both lifetime and adult physical and sexual abuse relative to the general population". Moore also posits some reasons why this is so. One reason is that men who abuse their partner are more likely to have multiple sex partners, thereby increasing the chance of passing on an STI. Another reason is the inability of women to negotiate safer sex practice with their partner, as aforementioned. However, according to her, it is not yet possible to draw definitive conclusions (Moore, 1999), hence the need for more studies on how intimate partner violence could enhance the transmission of STI including HIV. This present study will therefore be focusing on how intimate partner violence could hinder safer sex practice thereby causing the transmission of STI (including HIV) and probably unwanted pregnancy.

1.5 Purpose of the study

South Africa is one of the countries in which intimate partner violence has come under spotlight. Studies revealed that South Africa has the highest rate of domestic violence in the world. It is estimated that 1 in 8 women has been battered

by a partner in South Africa (National Population Unit, 2000:56). Violence against women is not however limited to battering in South Africa; rape is another incidence that is a major concern. It is estimated that 1 in 3 women has been raped (Jewkes, 1999).

Despite the campaigns and laws against gender violence, the incidence of violence is still very high in South Africa. The number of reported rape cases was 119,5 per hundred thousand persons in 1996 (Statistics South Africa, 2000). Even though the political/economic scenario is improving in South Africa, women are still struggling for survival as a result of violence being perpetrated by their partners.

The purpose of the study is to examine how violence among intimate (current or former) partners, whether married, cohabiting or dating, could be an obstacle to safer sex practice. Most studies on gender violence focused on factors enhancing it and some include its consequences. Only a few studies have been done on unsafe sex practice as a major consequence of intimate partner violence in South Africa. This study would therefore contribute to the knowledge of intimate partner violence as a barrier to safer sex. This is very important as a result of the fact that there is now the need for partners to practice safer sex if they want to avoid problems associated with sexual intimacy, such as unwanted pregnancy and STDs including HIV/AIDS. Also this study would also help in determining whether intimate partner violence hinders safer sex practice in South Africa.

1.6 Hypotheses and Research Questions

The three hypotheses that will be tested in this study are as follows:

1. Intimate partner violence reduces the likelihood of safer sex practice among women
2. The higher the socio-economic status of women, the greater the likelihood of condom use
3. The higher the socio-economic status of women, the lower the likelihood of intimate partner violence.

Some research questions that this study would try to answer include the following:

- Does violence in a relationship hinder the negotiation of sex between partners in intimate relationship?

- Does intimate partner violence contribute to the spread of Sexually Transmitted Diseases including HIV/AIDS in South Africa?
- Could high level of socio-economic status lessen a woman's chance of being abused?

1.7 Assumptions and Limitations

This study will be based on the assumption that the women in the 1998 South Africa Demographic Health Survey (the data that will be used in this study) wanted to practice safer sex but one of the factors that hindered was intimate partner violence.

A major limitation of this study is that the data to be used for quantitative analysis was not collected by the researcher; hence answers to some other relevant questions that would have been included in the questionnaire are not available. About 4.4% of the women in the SADHS (1998) reported that they have ever been raped (Jewkes, 1999:3), and this sample size is small and therefore cannot be considered as a representative sample of South African population. As aforementioned, most women find it difficult to report intimate partner violence.

Another limitation of this study is that the SADHS did not use measure(s) of abuse such as the Conflict Tactics Scale (CTS) and Sexual Experiences Survey (SES) that have been used to measure the severity of abuse (minor to major) in developed countries (Canada and USA) (DeKeseredy and Schwartz, 1998). The CTS and SES are questionnaires with standard questions about the experiences of violence in a relationship. As a result one might not be able to get a good comparison of results from this study with those from the developed world.

1.8 Data source and methods

This study is focusing on intimate partner violence as an obstacle to safer sex practice in South Africa. Only a few studies in South Africa have used quantitative method to analyze data on this kind of study, hence the need for this present study to use quantitative analysis. However, to give a full picture of intimate partner violence, qualitative method was also used.

The data that was used for the quantitative analysis is the South Africa Demographic and Health Survey (SADHS) data. The SADHS is a nationally representative sample survey that was designed to provide information on various

demographic and maternal, child, and adult health indicators in South Africa (Department of Health et al., 2002). A section of this survey contains information on violence against woman, which makes it a good source of data for this present study.

As a result of the fact that quantitative analysis of the SADHS might not give an in-depth understanding of intimate partner violence preventing condom among women, the study also included a qualitative analysis of some case studies of abused women. The case study research technique was used for the qualitative analysis as a result of the need for a detailed investigation of how intimate partner violence prevents safer sex. These case studies were collected from an organization that deals with abused women. The focus of the analysis was on women that have been in an intimate relationship with their male partners.

At the conclusion of this study, the triangulation method[1] used in this study yielded some interesting findings that provided answers to the research questions (of this study). These findings were also used to make some recommendations that could help in addressing the problem of intimate partner violence in our society.

[1] Combination of quantitative and qualitative methods

Chapter 2

Literature Review

Intimate partner violence (IPV) is regarded by many researchers as one of the most common forms of violence against women. The results from 50 population-based surveys worldwide show that, over the past 16 years, between 10 and 67 percent of women report being abused by a partner at some point in their lives (Coker and Richter, 1998:62; Heise et al., 1994; Blanc, 2001:195; Watts and Zimmerman, 2002). Most of the questions that women are asked are about their experiences of acts of violence, for example, "has a current or former partner ever hit you with his fist or with something else that could hurt you?" (Watts and Zimmerman, 2002). This thereby resulted in more reports about physical violence and less about other forms of IPV such as sexual and psychological abuse, which Blanc (2001) believes might cause greater damage. Blanc (2001) argues that the damage to women's physical and mental well-being can be greater than the immediate injury, and this (damage) includes depression, anxiety, gynaecological problems (e.g. chronic pelvic pain), miscarriages, etc.

The World Health Report (1997) (cited in Watts and Zimmerman, 2002) also reveals that globally, a third of all women have experienced violence in intimate relationships. Reports from studies conducted in both developed and developing countries have revealed that intimate partner violence is not endemic to any particular region and also it cuts across all cultures and races of the world. Also many of the studies only focus on physical abuse, even though there are other forms of intimate partner violence such as sexual and psychological abuse. This review will therefore not only consider the studies that have been done in developed and developing countries simultaneously but also the different forms of intimate partner violence.

Many studies that have been conducted on intimate partner violence have revealed that there are some factors that contribute to intimate partner violence. These factors that enhance intimate partner violence would be considered in this review.

2.1 Factors enhancing Intimate Partner Violence (IPV)

The main factor that enhances violence in an intimate relationship is unequal power relation among partners. Unequal power relation not only makes one partner to override the other but also makes him to get away with whatever he does. Power could be defined as

> the relative ability of one partner to act independently, to dominate decision-making, to engage in behaviour against the other's partner's wishes, or to control a partner's actions (Pulerwitz et al., 2000 as quoted in Blanc, 2001:189).

According to Blanc (2001:190), gender-based power in sexual relationships is frequently unbalanced and this thereby makes women to have less power than men. She also posits that (unequal) power relations have a clear causal link with violence or the threat of violence within relationships, and violence in turn can result in some negative consequences. Intimate partner violence could therefore be considered as the most compelling manifestation of unequal power in sexual relationships (Blanc, 2001). In other words, unequal power relation is likely to enhance violence in an intimate relationship since men normally dominate or control their partners and any resistance on the part of the women might result in violence against them.

Unequal power relations have been observed in reproductive decision-making especially among couples in developing countries, especially sub-Saharan Africa. Men not only decide the number of children (to be had) but also whether or not their spouses would use contraception. Any attempt on the part of the woman to do or make decision that is suitable for her is likely to result in violence (Blanc, 2001) and these could lead to some negative consequences. A multivariate analysis of the effect of violence on reproductive decision making in Uganda, revealed that wives who experienced violence in a relationship, were less likely to use contraceptives (Ezeh and Gage, 1998 cited in Blanc, 2001). This means unequal power relations could cause intimate partner violence, which in turn could result in other negative consequences.

In another research conducted in Uganda, the issue of power also came up when the women reported that they are vulnerable to intimate partner violence because of lack of decision-making powers in matters of sex. As a result of this they

are more susceptible to infections from husband to whom traditions permit multiple partners (Orubuloye et al., 1993). One reason that was given for their powerlessness is that the community accepts a level of violence by husbands towards wives, especially when wives refused what is considered as the conjugal right of men (Orubuloye et al, 1993:860). This therefore shows there is a connection between power and violence.

Ulin (1992) also believes the issue of power needs to be put into consideration when dealing with decision-making among partners in an intimate relationship; and considers control as an important dimension of women's power. She posits that lack of access to, and control of resources for decision-making, particularly in intimate relationship is key to the vulnerability of women and children in the AIDS epidemic (Ulin, 1992:64). Not being able to make decisions related to sexual matters is however not the only way in which women could be made vulnerable to violence; lack of control over some resources such as land and money could be linked to it. Some researchers (Orubuloye et al, 1993; Ulin, 1992) have also linked lack of control over these resources (by women) as a factor contributing to intimate partner violence. According to Obbo (1989, cited in Orubuloye et al, 1993:860) in Uganda, most women do not have access to land; most of them even get married in order to have access to land. As a result of this it is mandatory for them to provide their husbands with sexual services in all circumstances. This, of course could lead to sexual abuse since the women are in no position to negotiate safer sex practice due to their dependence on their partners.

One consequence of lack of control over resources (such as land and money) is economic and financial dependence of women on their partners. According to Varga (1997:48), power inequity...and financial dependence of women upon their partners could present significant obstacles to sexual decision-making (and this could ultimately lead to sexual abuse). Orubuloye et al (1993:860) also believe that economic dependence of women could make a woman to be in a position where she would not be able to say no to a sexual demand even when she knows it is not safe for her. According to them, the rural African women are highly disadvantaged due to a lack of control over or inadequate access to land and cash. Husbands who have gone to the cities often set up new households and also have multiple sexual partners, and they can still demand their matrimonial sexual rights whenever they

return to rural areas (Orubuloye et al., 1993). This thereby makes the women to be vulnerable to sexual abuse (intimate partner violence).

Another factor that many researchers have pointed out as causing intimate partner violence is the ideology of patriarchy (which is also related to the issue of power). According to a study conducted by DeKeseredy and Schwartz (1998) on woman abuse on campus using the results from the Canadian National Survey, men who espouse patriarchal beliefs and attitudes are more likely to engage in sexual, physical and psychological abuse. Patriarchal ideology is defined as a discourse that supports the abuse of women who violate the ideals of male power and control of women that are in intimate relationships. They cite women's obedience, respect, loyalty, dependency, sexual access and sexual fidelity as the relevant themes of this ideology.

Another study (in US) of sixty men who had committed an act of violence against an intimate female partner, revealed that men that reported a high need for dominance (caused by patriarchal belief) also reported greater frequencies of physical violence (Mauricio and Gormley, 2001). This thereby shows that if a man espouses patriarchal beliefs and attitudes, he tends to exercise power over his partner, which might sometimes lead to violence against his partner. In a study conducted in South Africa, patriarchy is also considered to be a factor causing intimate partner violence. According to Rachel Jewkes et al (1999), it was found that men as well as women themselves accept ideas that women are subservient to men in relationships, also they believe that abuse is their entitlement.

Another factor that enhances intimate partner violence is peer pressure. In a study of adolescents carried out in South Africa, it was revealed that peers reinforce the pressure to engage in sex. Many of the adolescents reported that sex was a strategy to avoid ostracism; one (young) woman said, "if you want to belong to that group you end up doing it, otherwise you become isolated and nobody wants that" (Wood et al, 1998). It was reported that many of the adolescents ended up being sexually abused by their partners. Varga (1999:30) also posits that peer pressure not only pushes youth to engage in early sex but also to engage in multiple sexual partnerships, as this is the part of the requirement for peer acceptance.

Peer pressure or male peer support has also been revealed to be a determinant of intimate partner violence in a relationship in another research. According to DeKeseredy and Schwartz (1998:99), "male peer support refers to

attachment to male peers and the resources that these men provide which encourage and legitimize woman abuse" .The same study conducted by DeKeseredy and Schwartz (1998) revealed that male peer support contributes to female victimization in Canadian College courtship. Other variables that were included in the correlation analysis are the attitude and belief variables. The three variables account for 21% of the variance in woman abuse in courtship; thereby they believe this might be due to some missing variables. They identify these missing variables as 'past history of violence' and 'a history of learning about male dominance'. They posit that past history of violence does not mean only violence against girlfriends but also sisters, friends or relatives. Male dominance means growing up in a family marked by parental familial patriarchal values and norms, which is an enabling factor that allows a woman to engage in woman abuse as he grows up (DeKeseredy and Schwartz, 1998).

Other studies have also revealed that past history of violence is a factor to be reckoned with when considering violence against women. A study (in US) conducted by Forbes and Adam-Curtis (2001:884) on 464 freshmen revealed that there is a relationship between aggression in the family of origin and the experience of sexual aggression and coercion in males and females. The stepwise regression for males indicated that conflict resolution strategies that involve the use of physical aggression, particularly from the mother, and the relative absence of reasoning, particularly from the father, could be used to predict sexual aggression and coercion (Forbes and Adam-Curtis, 2001:884).

In another study, this factor (history of violence) was also confirmed to be the cause of violence against women in some relationships. This study was conducted at three municipalities in Cape Town among 1394 male workers. It was found that men who reported abuse had witnessed their mother being beaten during their childhood and also some had witnessed their sisters' abused by their husbands and boy friends. There was on average a 50% chance for the respondents who had witnessed abuse during their childhood to report abuse in their relationships (Abrahams, Jewkes and Laubsher, 1999).

Alcohol consumption is another risk factor that causes violence in a relationship. Many studies revealed that there is a link between alcohol consumption and violence against women. According to DeKeseredy and Schwartz (1998:118), it is argued that men who drink more often and more heavily are more likely to be

sexual and physical assault offenders. Also women who drink heavily are more likely to be assaulted. They found this to be true in their study (in Canada), in which 15.2% of the light drinkers and 31.5% of the heavy drinkers among men claimed to be physical or sexual abusers. Among the women, 37.7% of the light drinkers and 61.9% of the heavy drinkers were victimized. They consider both relationships to be statistically significant (DeKeseredy and Schwartz, 1998:122).

In another study of domestic violence in Western Cape (South Africa) conducted by Mathews and Abrahams (2001), the majority of the women interviewed linked the abuse of alcohol and drugs to their 'partners' abusive behaviour. They therefore attributed the change in their partner's personalities to substance abuse and reported, " when he is sober he is not violent". These women believed that an "end" to substance abuse would automatically result in an "end" to the violence in their relationships.

The National Family Violence Survey (NFVS) and the Violence Against Women Survey (VAWS) which are representative surveys in the United States and Canada respectively revealed that the percentage of wife assault cases in which male partners are described by victims as drinking at the time of the assaults range from 22%. Also, these surveys estimate that among binge drinkers, the rate of violence against female partners is three to five times higher than among abstainers (19.2% compared to 6.8% in the NFVS and 11% and 2% in the VAWS) (Johnson, 2001:54). A study conducted by Johnson (2001) through the secondary analysis of the National Violence Against Women Survey (in US) revealed that that indeed there is a link between alcohol and spousal abuse. The study found that men who were drinking at the time of the assaults were more likely than non-drinkers (65% compared to 40%) to use very serious acts of violence against their spouses. In other words the more a man drinks, the greater the chance that he will be involved in incidents of violence against his spouse. She therefore suggests that alcohol has the ability to reduce inhibitions and increase aggression and also to allow a time-out in which unacceptable behaviour is allowed to occur (Johnson, 2001:64).

Also in another study conducted (in US) in order to find out the expected effects of alcohol on another person, it was revealed that subjects evaluated a drinking woman as more sexual than a male counterpart and more impaired, and sexually available, and likely to engage in foreplay and intercourse than non-drinking female. Also, women consider a woman who consumes alcohol on a date as more

vulnerable to sexual assault risk than a non-drinking woman. In other words, individuals who consume alcohol are perceived as more sexually available than non-drinkers are (Corbin et al., 2001:297-311). This therefore suggests that a woman that drinks has the tendency to be abused especially if her partner also consumes alcohol. Corbin et al. also found out in a study of 238 female undergraduates that women with a history of attempted or completed rape reported greater alcohol consumption, more consensual sexual partners, and less likelihood of resisting unwanted advances compared with non-victimized women.

Culture or traditional custom is another factor that many researchers have pointed out as a cause of violence against women in intimate relationships, especially in African societies. The paying of bride wealth is one custom that is regarded as causing violence among partners. Bride wealth, also known as bride price 'lobolo', 'lobola' or 'bogadi' is an important part of marriage in customary and civil law marriages in Africa (Green, 1999).

According to Green, it used to be given to the bride's family in compensation for the loss of her labour and fertility as well as a symbolic token of a woman's value (1999:26). Now bride price has been commercialised in almost every African society. It used to be in form of livestock or some other commodity, but now it is given in form of cash. As a result of the fact that the bride's family usually sees it as a way to make some money, thereby charging an exorbitant price, the husband-to-be also feels as if he is 'buying a wife'. (Green, 1999). Previous studies have confirmed that this has made it possible for the man to beat or sexually assault his spouse since he feels he has automatically bought her through the bride price system.

A study conducted in KwaZulu-Natal found that many men feel that the payment of bride wealth gave them the right to demand sex whenever they desire. And if the spouse refuses, the man has the right to have forced sex with her (Maharaj, 2001). This therefore suggests that bride wealth enhances violence in intimate relationships especially where the price is high.

Pornography is another factor that has been identified by researchers to contribute to violence against women in an intimate relationship. Of the 1638 women in the study conducted by DeKeseredy and Schwartz (1998:110), 137 (8.4%) stated that their dating partners trying, to get them to do what they had seen in pornographic media, upset them. Also, of those who were sexually abused, 22.3% had been upset by attempts to get them to imitate pornographic scenarios. They therefore concluded

that there is a significant relationship between being upset by men's attempts to imitate pornographic scenes and victimization.

Poverty is another factor that enhances intimate partner violence. In many developing countries, especially in sub-Saharan Africa, majority of women are living below poverty line, and this has made them to be particularly vulnerable to intimate partner violence. Many of them depend on their partners for their livelihood; hence they are not in a position to negotiate safer sex. It was reported in a study that even though the women knew about safer sex practice, they did not engage in it because they needed the money they got from their partners when they succumbed to their wishes, by not using a condom (Preston-Whyte, 1995:217). In other words, they could be forced to have sex with their men and would not be able to say no since they are depending on them financially.

It was also discovered in the same study that unemployment could make a woman to be vulnerable. According to the women, if they had jobs they would not need to depend on the men, hence they would be able to practise safer sex, which in turn would make them less vulnerable to intimate partner violence (Preston-Whyte, 1995:217). Another study in Sierra Leone also revealed that being currently unemployed is significantly associated with intimate partner violence (Coker and Richter, 1998: 68)

One important factor that could be said to perpetuate intimate partner violence in many societies is having a wrong perception of love. Many studies revealed that men and sometimes even women believe that beating a woman is a way in which a man can express his love for her (Dixon-Mueller, 1993:275; Rachel Jewkes et al, 1999:8; Kim and Motsei, 2002). According to Dixon-Mueller (1993), a researcher in one Indian village reported that wife-beating was regarded as a custom that was justified as a way of showing regard. The researcher said, "It is not surprising if sometimes a man gets carried away and hurts his wife…but the intention is noble- to demonstrate love". Another research conducted in South Africa revealed that those are in a position to know better have the same perception about love. According to Kim and Motsei (2002), during a focus group discussion, male nurses listed a wide variety of occasions that justified beating a woman; not obeying their husband, shortcomings in household duties, infidelity, etc. They also described beating as a means of expressing love or forgiveness for a woman's perceived transgressions. Their female counterpart also believed the same thing and even said that women

were responsible for certain behaviours and attitudes, which could provoke intimate partner violence (Kim and Motsei, 2002).

2.2 Forms of intimate partner violence

Most of these studies, especially quantitative ones, focus on physical and sexual abuse, however intimate partner violence is much more than physical or sexual abuse. Other forms of violence that have been identified in some studies are psychological and economic abuse. In a study conducted in Bellville and Paarl in the Western Cape (South Africa), it was found that the most common forms of violence reported by women were physical and psychological abuse with an average of 81% of cases experiencing both forms of violence (Mathews and Abrahams, 2001). An example of a form of psychological abuse experienced by the women is when their partners have other girlfriends and they are kicked out of the house. One of the women said, "he has girlfriends and every time he kicks me out when they are in the house" (Mathews and Abrahams, 2001:19).

The other form of abuse reported by these women in this same study is economic abuse. They reported that their partners not only withhold money but also do not contribute financially to house keeping (or home maintenance). One of them said: "he doesn't give me money for groceries, let alone for school fees" (Mathews and Abrahams, 2001:19). Another form of economic abuse is that the partner prevents a woman from working and at the same time does not give her money. According to Jewkes et al. (1999), preventing women from working is not only a form of abuse but also it makes them vulnerable to other abusive acts.

2.3 Consequences of intimate partner violence

One of the consequences of intimate partner violence in a relationship is inability to practice safer sex, which could lead to unwanted pregnancy and the transmission of sexually transmitted infections (STIs) including HIV/AIDS. Some studies have revealed that intimate partner violence could lead to unsafe sex practice. One of such studies conducted by Katherine Wood and Rachel Jewkes (1997) among pregnant teenagers in an African township in Cape Town brought out the fact that violence is the order of the day among partners in sexual relationships. According to Wood and Jewkes (1997), the young women reported that men use

violent strategies from the beginning of relationships, and in most cases they forcefully initiated their partners who often had no knowledge about sex. Wood and Jewkes (1997) also posit that this is in line with findings from another similar study in which 30% of the girls reported that their first encounter with sex was with force.

In another study, Wood et al. (1998) revealed that non-pregnant teenagers experience similar levels of abuse, although forced sexual initiation was more commonly reported among pregnant teenagers. 31% of pregnant and 18% of non-pregnant teen-agers said they were forced to have sexual intercourse the first time.

Violence against women is however not limited to rape or 'sex by force' in South Africa; Wood and Jewkes cite another example of a study of 600 pregnant and non-pregnant teenage women in Cape Town, which revealed that 60% had been beaten by their male partners. The pregnant group reported they had been beaten more than ten times during their average of two years of sexual activity (Wood and Jewkes, 1997). Despite the occurrence of violence, only 13% had terminated their relationship while those still in a relationship are still in it because of fear. They believe they will still experience violence if they leave. When asked what the consequences of refusing to have sex would be, 75% of pregnant and 69% of non-pregnant teenagers said they would be beaten, and 63% of the former and 60% of the latter said they feared their partner would leave them (Wood et al., 1998).

Also, in this study by Wood and Jewkes, it was revealed that women find it impossible to negotiate safer sex with their partners. They are beaten or forced to have sex with them whether it is safe or not. Some of the girls even described how their partners tore up their clinic contraceptive card in anger (Wood and Jewkes, 1995).

In another research conducted by Varga (1997) on sexual decision-making and negotiation in the midst of AIDS among young men and women in KwaZulu Natal (South Africa), it was found out that there were communication barriers among partners as a result of threat of rejection or stigmatisation and fear of physical abuse or coercion. As a result of this, it was difficult for a woman to discuss HIV/AIDS with her partner. One woman said, "I would be afraid to talk to him (boyfriend) about AIDS. He is not the kind of person I can discuss such things with. It is not that kind of relationship "(Varga, 1997:54). Most of these women remain silent even though they are aware of HIV/AIDS and also the fact that their partners are not faithful to them. However due to the fear of being beaten they decide not to negotiate safer sex

practice with their partners. Another woman said, "No, we don't discuss AIDS, I'm scared of him because he used to beat me. So I don't want to talk about things that might make him upset" (Varga, 1997:54). This could be considered as another form of emotional abuse since they live in fear of their partners hurting them if they try to negotiate safer sex with them thereby endangering their lives.

The study carried out by Varga also reveals that men use force to gain control over women. As far as they are concerned sex is a tool for exercising authority in a relationship. According to one man, "it's not enough to get her to fall in love with you. ... To show that you control the relationship you must be able to show your friends that you have slept with her" (Varga, 1997:55). Since most of these men are more interested in exercising authority in a relationship, this is likely to result in sexual coercion moreover there is no way in which safer sex could be negotiated. In fact many of the men in the study believed that sex must take place within the first two weeks of a relationship (Varga, 1997). This shows that immediately a man starts dating a woman, the next thing is sex, whether she is ready or not.

Usually having one girl/woman is not enough for a man; according to Varga (1997), male participants described strategies resulting in many partners as a reflection of male intelligence, cunning and wit. Also, among the Zulus, a man with many partners is 'isoka' while a man with one or none is 'isishimane' which is an insulting and derogatory label (Varga, 1997;55). Men in another study (in South Africa) also reported the need for men to control women in a relationship (Abrahams et al., 1999). According to Abrahams et al (1999), conflict was associated with attempts by the men to control their women, their sexuality and their households. This is also in line with other research that showed that control lies at the heart of the meaning of being a 'real' man among many groups in South Africa. Therefore violence is used to maintain control and dominance as well as real or imagined threats to 'manhood' (Abrahams et al., 1999).

These studies show that there is no way in which safer sex could be discussed in this kind of relationships since the men are more interested in satisfying their sexual desires and least concerned about the consequences, which include transmission of STIs and unwanted pregnancy. According to Manzini (2001:44), forced sex and rape exacerbate the risks of unwanted pregnancy and exposure to STIs including HIV, as these young women (in South Africa) have no control over the situation and their ability to negotiate contraceptive use is negated. In some cases,

the desire to use contraceptives provokes the man thereby resulting in more violence in the relationship.

Wood and Jewkes (1997) also reported in their study of teenagers in South Africa, that their partners tore their contraceptive cards, and even said that contraceptive methods caused infertility, 'disabled babies' and vaginal 'wetness' that diminished male sexual pleasure; which shows ignorance on the part of these men.

Most of these studies in South Africa have revealed that intimate partner violence usually results in unsafe sex practice. They however only considered teenagers or pregnant teenagers; therefore there is need for more studies on older women that would be more representative of the South African population. Also there is need for studies that use quantitative analysis in a way that the actual variables (factors) that enhance intimate partner violence would be detected after controlling for other variables. This present study provides such information.

Chapter 3

Conceptual and Theoretical Framework

3.1 Patriarchal Theory

This research is informed by the patriarchal theory, which is a strand of feminist theory. In order to understand how patriarchal theory evolved, there is need to examine feminist theory first.

The feminist theory posits that women not only suffer discrimination because of their sex, but also they have specific needs which remain negated and unsatisfied and before the needs could be met, there is need for a radical change in the social, economic and political order (Mitchell and Oakley, 1986:8). This need for a radical change was brought about by the women's movement in the 1960s, which saw that women have been under oppression for centuries and that there is need for this to change. These women known as feminists were able to break the conspiracy of silence about the oppressive and unequal man-woman relationship as they wanted it to come to an end (Mies, 1986:6).

Even though the first feminist movement concentrated on the public sphere (politics and economy), the recent new movement focuses on the private sphere, that is, the intimate relations between men and women. This came as a result of the fact that violence, humiliation and coercion characterized most intimate sexual relationship between men and women (Mies, 1986:6). Women are not only being oppressed in the public through the structures that favor men but also in private. This therefore sparked the need for a radical change that must start at home.

Radical feminism is one of the perspectives of feminism that strongly believes in the need for this radical change especially with regards to the sexual relationship between men and women. "Radical feminism is distinguished by its analysis of gender inequality in which men as a group dominate women as a group and are the main beneficiaries of subordination of women " (Walby, 1990:3). In other words, women have been placed in a position or system whereby men exercise their authority over them in every area of life.

One area in which this control (authority) is prominent, according to Maria Mies (1986) is in the area of 'body politics'. She believes that violence and coercion are the main mechanisms by which the unequal power relation in the area of 'body

politics' was maintained. Women started realizing that their own bodies had been alienated from them and had been turned into objects by men, who either batter or rape them. Women also started understanding (as a result of the movement) male dominance, or patriarchy as it then began to be called, which had its origin not only in public politics but also in body politics (Mies, 1986:25). Through this patriarchal system women's bodies are put under the control of men. For instance, it was (still is in some societies in sub-Saharan Africa) a taboo for a woman to demand sex from her partner whereas the man cannot only demand for it but also force her to succumb if she is not interested.

Radical Feminists later started using the term patriarchy to denote the dominance of men over women. According to Coward (1983:7), the term patriarchy has been widely used as the foundation for a specifically feminist investigation of sexual relations. Even though it has been used interchangeably with 'sexism', which means that there is one sex that dominates another which is subjected, patriarchy has now been advanced as a theoretical explanation for the subordination of women.

Sylvia Walby (1990) in *Theorizing Patriarchy* defines patriarchy as a system of social structures and practices in which men dominate, oppress and exploit women. According to her, male violence against women is considered by Radical Feminists as part of a system of controlling women and do not view rape and battering as isolated instances caused by psychological problems in a few men. Walby also argues that male violence against women has all the characteristics one would expect of a social structure and therefore it could not be understood outside an analysis of patriarchal social structures (Walby, 1990:128). This could be considered as the reason why men are usually the perpetrators of intimate partner violence and also why they usually get away with it in most societies. In other words, intimate partner violence occurs simply because the societies have been structured to accommodate it.

According to Walby (1990:2), "the concept and theory of patriarchy is essential to capture the depth, pervasiveness and interconnectedness of different aspects of women's subordination, and can be developed in such a way as to take account of the different forms of gender inequality over time, class and ethnic group". In other words, the theory of patriarchy best explains why women have been oppressed for ages (in every area of their lives) in almost every society across the globe. Mannathoko (1992:76) also concurs and posits patriarchy to be a form of male

domination based on the powerful role of a father. She however points out the fact that not all forms of gender-stratified systems are based on patriarchy. According to her, some communities in Africa are not patriarchal; she cites the example of Malawi where the power of males is founded on their collective adult maleness as depicted by men's houses, warfare and initiation ceremonies. However, these communities are also oppressive to women even though they might not be regarded as patriarchal (1992:76). It could therefore be said that there is an element of patriarchy in every society where men dominate women, whether the society is patriarchal or not.

Mies (1986), also thinks 'patriarchy' is an appropriate term to use for the system of male dominance in our societies. She mentions the fact that there have been discussions in the feminist movement on whether it is correct to consider the system (of dominance) under which women suffer today as a patriarchal system. She posits that even though 'patriarchy' literally means the rule of fathers, today's male dominance goes beyond that and now includes the rule of husbands, male bosses, ruling men in most societal institutions, in politics and economics (Mies, 1986:37). Patriarchy now encompasses both the private and public spheres, in sum.

According to Mies (1986), the concept 'patriarchy' was rediscovered by the new feminist movement as a struggle concept due to the need of the movement for a term by which the totality of oppressive and exploitative relations that affect women could be expressed as well as their systemic character. Also the term 'patriarchy' denotes the historical and societal dimension of women's exploitation and oppression (Mies, 1986:37). 'Patriarchy' also offers an explanation for why women have been under oppression for many centuries; it is only in recent times that they started questioning their role as the 'underdogs' in the society.

Mies (1986:38) further writes that she prefers the term 'patriarchy' because it enables one to link women's present struggles to a past, and thus gives the hope that there will be a future as well as an end. However, it might be very long before violence against women would be eradicated considering the way the patriarchal system is embedded in our societies.

One reason why patriarchy is deeply embedded in societies all over the world is because the family is maintained by patriarchy (Green, 1999:17; Meer et al, 1991). According to Green (1999:17), patriarchy is all the more pernicious because it is cloaked (disguised) and also the subordination of women is simply rationalized as due to 'tradition' or 'nature'. Meer et al (1991) concurring, point out that patriarchy

made it the prerogative of the male head of the family to share out resources and that in itself results in domination. For instance, in the study conducted by Meer et al, it was reported that when men control the household income, they spend some of it on drinks, cigarettes and races therefore forcing the women to work in order to earn more wages to support the family (Meer et al, 1991).

Green also points out that patriarchy produces and is reproduced by acts of gender-specific violence committed within the family and rationalized as being within the interests of the group (Green, 1999:17). Green describes how women are viewed as occupying the same social standing as children in some African societies; intimate partner violence is considered as an expression of caring discipline (1999:23). In other words, battering or sexually abusing is done in the interest of women. Many even believe that women desire and provoke their beatings, and that they should also accept such treatment for their failures (Green, 1999:27). Green cites a case study of Dorcas, a 38-year-old Tanzanian woman married for ten years who rationalizes her treatment as follows:

> He calls me "barren" and attacks me at the slightest excuse. Because I cannot have children I just remain silent and accept it. It's really my fault—if I had borne children perhaps he would have been kind to me. He has children by another wife, but because he had to pay a lot of bridewealth for me and we were married in church he says he cannot divorce me.... (TAMWA, 1993: 114 cited in Green, 1995:26)

It is obvious that Dorcas, the woman in this case study believes that it is right for her husband to punish her for failure to bear children and also she feels responsible for it. The only reason why a woman would blame herself for being barren is because of the stereotypes that have been instilled in her as a result of the patriarchal system. For instance, in a patriarchal society, a woman is considered to be useless if she cannot bear children, as a result of the belief that the sole purpose of a woman is to reproduce. In most cases the woman is blamed for infertility whereas it could be the man that is infertile.

Many studies (Orubuloye et al, 1993; Varga, 1997; Meer et al., 1991) have shown that patriarchy enhances the chance of a woman experiencing violence or abuse in relationships. This is because most cultures and traditional norms are

'patriarchal', that is, they are structured in a way in which men can exercise authority over women. One way, in which this happens, is through the marriage institution.

In many societies patriarchy is very evident in the marriage institution, In fact the foundation of most marriages could be said to be based on the system of patriarchy, that is, domination of a woman by her husband, which sometimes cause domestic violence. Wini Breines and Linda Gordon (cited in Green, 1999) cite the example of battering as the extreme end of a continuum of the power asymmetry institutionalized in marriage. As a result of this "violence by husbands against wives should not be seen as breakdown in social order but an affirmation of a particular sort of social order, namely a dysfunctional one" (Green, 1999:28). This is to say that it is the patriarchal system that enhances violence against women in a marriage and similar relationship (intimate partner violence). Therefore where the incidence of abuse is high, the prevalence of battering, the patterns of outsiders' responses, and the complex constellations of behaviors in many violent relationships indicate that wife battering is a behavior that emerges out of the social relations of dominations (Green, 1999:28).

Green (1999) cites some examples of how men dominate their wives in some societies. In Zambia, for instance, it is not a crime if a man beats his wife for refusing him sex. In Kenya, heterosexual intercourse between Gusii males and females is considered to be an act in which a man overcomes the resistance of a woman and causes her pain. A groom is regarded as 'a real man' when the bride is unable to walk after the wedding night (Green, 1999:34-35). These examples are also common in other societies; these show that patriarchy encourages the men to do what they want with their wives when trying to boost their ego as men. It could therefore be posited that patriarchy enhances intimate partner violence in our society.

One way by which patriarchy enhances intimate partner violence is through the inability of women in intimate relationships to negotiate safer sex practice. In patriarchal societies, a husband has absolute right over his wife and this is not limited to sexual matters. Apart from lack of decision-making powers in matters of sex, most women lack the right of ownership, control over, or adequate access to land (Orubuloye et al, 1993). Some studies have also shown that this lack of control over sexual matters and resources is a contributing factor to intimate partner violence (Orubuloye et al, 1993; Worth, 1989; Ulin, 1992; Varga, 1997), which ultimately leads

to unsafe sex practice among women. The diagram below shows the inter-relationship between patriarchy, intimate partner violence and unsafe sex practice.

Fig. 3.1:Inter- relationship between patriarchy, intimate partner violence and unsafe sex practice

In order to understand the inter-relationship between these three concepts, patriarchy and intimate partner violence and unsafe sex practice, it is imperative to understand how they would be defined for the purpose of this present study.

Patriarchy – any system or practice that dominates, oppresses and exploits women (Walby, 1990).

Intimate partner violence - any form of violence or abuse that is perpetrated by a man against an intimate female partner, that could result in physical, sexual, and emotional suffering (or harm) on the part of the woman.

Safer sex practice – any form of protected sex that could prevent unwanted pregnancy and sexually transmitted infections (including HIV). Even though safer sex entails more than the use of condom (others are non-penetrative sex and being faithful to one partner) (Varga, 1997:47; AIDS Action, 1999) this study will focus only on condom use among intimate partners.

Orubuloye et al (1993) in their study illustrates the inter-relationship between patriarchy, intimate partner violence and safer sex. It was reported that women in Eastern and Southern Africa are more likely to experience intimate sexual violence as well as practice unsafe sex as a result of their patriarchal societies which made them to be at a greater economic and [sexual] decision-making disadvantage to their husbands. Orubuloye et al cite an example of a study done in Uganda which revealed that wives are unable to refuse sex and insist on safer sex because of control of land and other resources by men, "a situation established by the patrilineal tradition" (Orubuloye et al, 1993:860). The fact that these women are unable to refuse their husbands sex means that it is possible for their husbands to force them to have sex, and this could be considered as sexual abuse, a form of intimate partner

violence. This therefore shows that patriarchy, intimate partner violence and unsafe sex practice are interrelated.

According to Khana et al (2000), the sum total of intimate partner violence can be viewed as one of the many forms of patriarchal social control. This is due to the fact that violence is an issue of power relations between men and women and also each of the forms in which it is seen serves to keep individual women within the control of individual men. In this study, these different forms of intimate partner violence was examined and also how these could prevent safer sex practice, which is regarded as one of the consequences of intimate partner violence against women. The results of this study yielded some interesting findings that made one to deduce that indeed intimate partner violence is an obstacle to safer sex practice. These findings are examined in chapters five through six.

Chapter 4

Methodology

This research uses secondary data for both the quantitative and qualitative analyses. The sources of the data for both methods, variables and methods used, are discussed in this section.

4.1 Data and Variables

The South Africa Demographic and Health Survey data was used in the quantitative part of this study. The SADHS is a nationally representative sample survey that was designed to provide information on various demographic as well as maternal, child, and adult health indicators in South Africa (Department of Health et al., 2002). A section of this survey contains information on violence against women, which makes it a good source of data for this kind of study.

The SADHS was conducted by the Department of Health, Medical Research Council and Macro International in 1998 and this is the first survey of its kind to be carried out in South Africa since the 1994 democratic national elections (Department of Health et al., 2002).

During the survey, enumeration areas (EAs) were selected based on the 1996 census data. Each of the nine provinces was stratified into urban and non-urban groups. A total of 972 primary sampling units were selected for the survey (690 in urban areas and 282 in non-urban areas). A total of 30 households were selected; 10 in urban EAs and 20 in non-urban areas. This led to a total of 12,860 households being selected throughout the country[2], however only 12,247 were successfully interviewed. In the households that were interviewed, 12,327 women were identified as eligible for the individual's interview but only 11,735 (95%) were interviewed (Department of Health et al., 2002). Considering the fact that more than 90% households (and women) were interviewed, the response rate of the survey could be said to be satisfactory.

In order to examine the link between intimate partner violence and safer sex practice, this research only focused on the women that reported that they have ever experienced intimate partner violence. A variable was created with the coding, 1 for

[2] Interviewers were instructed to include any second household residing on a selected plot, thereby resulting in more than the expected number of 12,540 households selected.

those who reported intimate partner violence (IPV) and 0, for those that did not report it. A sub-sample of those who reported IPV was selected. Only 1386 women reported that they had ever experienced the different forms of IPV such as physical, sexual and financial abuse. There is a lot of missing cases in the data, due to some women failing to report their experience of IPV. Under reporting is a common problem in surveys, especially when it concerns intimate partner violence. Women find it difficult to talk about their experiences of IPV as a result of shame or fear of recrimination (Heise et al., 1994). This sub-sample of 1386 women was used for the quantitative analysis.

In the survey, the women were asked if they had ever used a condom. This variable, ever use of condom, was the dependent variable. The main reason why condom was the only safer sex method considered in this study is because it gives dual protection from STIs and pregnancy. The independent variables are age, education, race, occupation, residence etc. As a result of the need to give a description of what intimate partner violence entails as well as the personal experiences of women that are in abusive relationships, a qualitative analysis was included in this study. Qualitative studies reveal insights that could not be captured by survey data (Blanc, 2001:193). However, unlike most qualitative research, secondary data was used. This is due to money and time constraints. Moreover, women who experience IPV normally find it difficult to relate their experience, however someone that has been trained to help the abused is in a better position to persuade them to share their experience. As a result of this, the data was collected from an organization that deals with abused women, that is, the Advice Desk for the Abused. This is a non-governmental organization that counsels and also helps abused women to obtain protection orders/interdicts. It also serves as a shelter for those women that are in need of a safe haven (Naidoo, 2002).

The data collected from this organization was taken from their records, obtained from interviews conducted by counselors with abused women. Some of the questions asked in the interviews include "when did abuse first begin?", "how often does abuse take place?", "types of injuries sustained", and "latest incident". The records from these interviews are kept in the form of case histories, that is, each record contains the story of how a woman experienced IPV. These case histories were analyzed in this study in order to be conversant with women's experiences of

IPV and also to examine how it could be an obstacle to safer sex practice, which is the aim of this research.

4.2 Methods

The triangulation method was used in this study to examine how intimate partner violence is an obstacle to safer sex practice. Triangulation is a research technique that is used to examine the same phenomenon from multiple perspectives. Also it enriches one's understanding as it allows new or deeper dimensions to emerge (Jick, 1983:138). Due to the weaknesses of using a single method, triangulation is considered as an effective method since the weaknesses (of a single method) would be compensated by the counter-balancing strengths of another (Jick, 1983). Triangulation method also increases the reliability and validity of the study.

In this study, the combination of quantitative and qualitative analyses was used in order to give a holistic explanation of how intimate partner violence could prevent safer sex practice among women. Quantitative analysis may be used to examine casual relationships between intimate partner violence and condom use. Qualitative analysis is used to complement the quantitative analysis. The qualitative part not only enriched this research but also gave insights to women's experiences of IPV.

The Quantitative data was analysed using SPSS [3], frequencies were used to describe and summarize the data while crosstabs were used to show the relationship between independent and dependent variables. Secondly, logistic regression was used to examine the effect of intimate partner violence on condom use. Logistic regression was chosen because it is a special form of regression whereby the dependent variable is a nonmetric variable[4] or dichotomous variable, condom use in this instance. A dichotomous variable is the term given to a non-metric variable that is transformed into a metric variable[5] by assigning a 1 or a 0 to a subject (Hair et al, 1998); in this case 1 represents condom use and 0, no condom use. Another reason why logistic regression was chosen is because of the ease of interpreting odds ratios.

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[3] Statistical Package for Social Sciences, a software used for quantitative data analysis

[4] Nonmetric variable - is a variable with a measurement that describes or identifies a variable by indicating the presence of an attribute, but not the amount (e.g. occupation- physician, attorney).

[5] Metric variable- is a variable with a constant unit of measurement. This measurement identifies or describes subjects (or objects) by the amount or degree to which the subject is characterised by the attribute (e.g. age, weight).

The main purpose of logistic regression analysis is the prediction of changes in the dependent variable, which is in response to changes in the independent variables (Hair et al., 1998). The logistic regression procedure uses the logistic coefficient to compare the probability of an event occurring with the probability of it not occurring. This is expressed in the form of odds using the formula below:

$$\frac{\text{Prob(event)}}{\text{Prob (no event)}} = e\,\beta o + \beta 1 X 1 + \ldots\ldots\ldots + \beta n \, x \, n$$

Where βo, $\beta 1$,....., βn are measures of the changes in the ratio of the probabilities known as odds ratio, xi is the independent variable (i= 1....n) and e the prediction error (Hair et al, 1998).

In order to analyse the relationship between the dependent (condom use) and the independent variables, some models were used in this study. The dependent variable for all models in this study is condom use. Each model estimates the coefficients.

The models used in this study include socio-demographic and sexual behaviour models. Also a bivariate analysis was done to examine the relationship between IPV and condom use. The results from the quantitative analysis were quite interesting, even though one needs to bear in mind that the sub-sample used in this study could not really be considered as a representative sample of South Africa due to the under-reporting in this data, as aforementioned the sample is not generalisable to the entire population of South Africa. The results should also be interpreted with caution because of the large amount of missing data.

For the qualitative analysis part of this study, case histories collected from the records of the organisation were analysed. The method that was used in analysing the case histories is known as the case study research technique. This method is used to understand an unusual event and also to give detailed and lengthy explanation for its occurrence (Campbell et al, 1999: 38). In this study, the method allowed one to examine the different forms of IPV and how women find it difficult to talk about safer sex with their partners. It also revealed some findings that could not be obtained for the quantitative analysis.

One limitation of the qualitative analysis is that the case studies were obtained from one organisation; information from more than one organisation would have yielded more results and also given a broader picture of what IPV entails. Also, it excludes abused women that did not seek assistance or help. Nevertheless, the

findings from the qualitative analysis were not only interesting but also complement the findings from the quantitative analysis. The next two chapters present the findings from the triangulation method used in this study.

Chapter 5

Intimate Partner Violence (IPV) and Condom Use

Previous studies (Varga, 1999; Worth, 1989) have shown that if women are to protect themselves from the twin risk of unwanted pregnancy and STIs (including HIV/AIDS), they need to use a condom. The occurrence of intimate partner violence (IPV) in many relationships is one reason why it has not been possible for women to engage in safer sex practices. This section focuses on IPV, the different forms of IPV, condom use, some of the characteristics of women that reported IPV and the relationship between IPV and condom use.

5.1 Intimate partner violence

Table 5.1 shows that out of the 11735 women that participated in the SADHS, only 1386 (11.8%) reported that they have ever experienced intimate partner violence (IPV). The number, 1386 for women that reported IPV could be regarded as an under estimation. This is because some women failed to report their experience of IPV. As aforementioned, many women find it difficult to talk about their experience of IPV due to fear of recrimination and shame. Also, in many cultures women are socialized to accept physical and emotional chastisement as part of husband's marital prerogative, therefore they consider IPV as 'normal' in their relationship (Heise et al., 1994:1167) and therefore fail to report it.

Table 5.1: Intimate partner violence

IPV	N	%
No	10349	88.2
Yes	1386	11.8
Total	**11735**	**100**

According to Heise et al. (1994:1166-67), the way IPV is defined is different in various studies and different set of questions are used to probe for its presence. Some studies ask if the respondents have been beaten or abused in a relationship while others ask about the lifetime experience of abuse. In this study, IPV not only encompasses the different forms of violence against women in intimate relationship, which include financial, sexual and physical abuse but also the past and present experience of IPV.

5.2 Types of IPV reported

Table 5.2 shows the different forms of intimate partner violence reported by women in the SADHS. Some of the women report more than one form of IPV. This shows that it is possible for a woman to experience different forms of IPV, such as financial, sexual and physical abuse. However, for the purpose of this study only one form of abuse per woman would be considered. The number of women that reported one form of violence is 1386.

Table 5.2: Types of intimate partner violence

Types of IPV	N (1386)	%
Financial abuse	235	16.9
Mistreatment by current/former partner	657	47.4
Left partner for being beaten	692	49.9
Sexual abuse	64	4.6
Note to table: Some women reported more than one form of IPV		

Out of 1386 women that reported IPV, 235 (16.9%) said that their husband did not regularly provide money needed for food, rent or bills. When asked if their current or former partner has ever kicked, bitten, slapped, hit with a fist, or threatened with a weapon, 657 (47.4%) reported that they have experienced this kind of mistreatment. About 50% (692) of the women reported that they have left a partner for being beaten. However, only 4.6% (64) reported sexual abuse. The reason why only a few reported sexual abuse might be that women find it more difficult to talk about sexual abuse than the other forms of IPV. This is in line with another study in South Africa, which shows that sexual abuse was less likely to be reported than other forms of abuse (Mathews and Abrahams, 2001).

5.3 Socio-demographic characteristics of the women

The socio-demographic characteristics of women could be considered as factors that can determine whether IPV is likely to occur or not. Table 5.3 shows the socio-demographic characteristics of the 1386 women that reported IPV in this study.

Table 5.3: Socio-demographic characteristics

Variable	N (1386)	%
Age		
15-19	158	11.4
20-24	276	19.9
25-29	240	17.3
30-34	254	18.3
35-39	219	15.8
40-44	138	9.9
45-49	101	7.3
Race		
Black/African	990	71.4
Coloured	219	15.8
White	126	9.1
Asian/Indian	51	3.7
Residence		
Urban	991	71.5
Rural	394	28.5
Education		
No education	77	5.5
Primary	409	29.5
Secondary	815	58.8
Higher	85	6.1
Occupation		
Professional	44	3.1
Clerical	76	5.5
Sales & Services	88	6.3
Skilled manual	80	5.7
Unskilled manual	320	23.1
Unemployed	779	56.2
Marital Status		
Never married	493	35.6
Married	456	32.9
Living together	220	15.9
Separated	216	15.6
Number of children		
No children	312	22.5
1-2 children	663	47.8
3-5 children	370	26.7
>5 children	41	2.9
Province		
Western Cape	191	13.8
Eastern Cape	131	9.4
Northern Cape	35	2.5
Free state	93	6.7
KwaZulu Natal	212	15.3
North West	62	4.5
Gauteng	437	31.5
Mpumalanga	122	8.8
Northern province	103	7.4

There are more women between the ages of 20 and 39, which is about 70% of the sample that reported IPV. Only 11.4% of respondents aged 15 -19 reported IPV. It is striking that this is not in line with other studies (Wood et al, 1998; Jewkes,

2002), which reported younger women to be more at risk of IPV. The reason might however be as a result of less number of younger women (between 15 and 19) in this survey.

More than 70% of these women that reported IPV are Africans, which is consistent with another study (Coker and Richter, 1998), while 15.8% coloureds, 9.1% whites and 3.7% Indians reported IPV. More than 70% of these women live in urban areas while only 28.5% live in rural areas. This does not necessarily mean that prevalence of IPV is lower in the rural areas but it might be that the women in the urban areas are more likely to report it, especially due to the existence of supporting structures such as shelter, health centres and police services in the urban areas. According to Heise et al. (1994:1168), "in South Africa, it has been estimated that in urban areas, fewer than one in twenty rapes are reported to the police, with even lower rates of reporting in rural areas".

Many of these women are educated; almost 65% of them have secondary and higher education while only 5.5% have no education. It is observed that there is a big difference in the number of women that have secondary education (58.8%) and higher education (6.1%). One striking thing is that even though most of them are educated, many are unemployed. About 56% said they have no employment, while only 8.6% are in professional and clerical occupation. This suggests unemployed women are more likely to report IPV. Coker and Richter (1998:68) also found unemployment to be significantly associated with IPV.

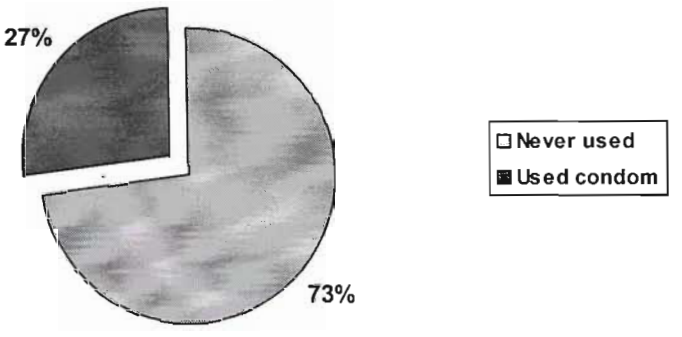
There is not much difference between those that have never married and those that are married. Almost 36% of these women have never been married while 32.9% are married women. This means marital status does not make a difference as far as IPV is concerned. Any woman could experience (or report) it, whether married or not. Also there is no difference in the number of women that are either living with a partner (15.9%) or separated (15.6%).

Many of these women have children (77%), while only a few (22.5%) have no children. Gauteng has the highest percentage (31.5%) of women that reported IPV, which is almost twice the percentage of women that live in KwaZulu-Natal (15.3%). However Northern Cape has the lowest percentage (2.5%).

5.4 Condom use

One of the objectives of this study is to examine the effect of intimate partner abuse on condom use. In order to know if the women had ever practised safer sex, they were asked if they have ever used a condom. Figure 5.1 below presents the percentage of women that used and never used condom. Many of these women had never used a condom, that is, 1010 (73%) while only 376 (27%) had ever used a condom. This is quite alarming when one considers the fact that these women are at risk of sexually transmitted infections (STIs) including HIV, especially if they are sexually active and unable to negotiate safer sex (Dixon-Mueller, 1993:269).

Fig. 5.1 : Condom use



One of the objectives of this study is to examine the relationship between intimate partner violence and safer sex practice, which is the use of condom in this instance. Even though the women in this study might have also used other methods of contraception, condom use is the only method that would be considered. The reason for this is that it is only condom that has the dual advantage of both serving as a contraceptive device and protecting against sexually transmitted infections (STIs) including HIV (Adetunji, 2000:196). Next to be examined is the relationship between condom use and the socio-demographic characteristics of women that reported IPV.

5.4.1 Socio-demographic characteristics and condom use

Table 5.4 below shows the relationship between the socio-demographic characteristics of women that reported IPV and condom use.

Table 5.4: Condom use by socio-demographic characteristics

Variable	Used condom (%) (n=376)
Age	
15-19	9.8
20-24	26.3
25-29	21.0
30-34	21.3
35-39	10.4
40-44	6.6
45-49	4.5
Race	
Black/African	64.4
Coloured	11.5
White	16.8
Asian/Indian	7.2
Residence	
Urban	83.2
Rural	16.8
Education	
No education	1.6
Primary	12.5
Secondary	72.3
Higher	13.6
Occupation	
Professional	7.5
Clerical	9.3
Sales & Services	7.2
Skilled manual	6.9
Unskilled manual	15.5
Unemployed	53.6
Marital Status	
Never married	39.5
Married	30.1
Living together	15.7
Separated	14.7
Number of children	
No children	30.1
1-2 children	50.7
3-5 children	18.4
>5 children	0.8
Province	
Western Cape	11.2
Eastern Cape	4.3
Northern Cape	0.8
Free state	5.6
KwaZulu Natal	17.3
North West	5.1
Gauteng	41.6
Mpumalanga	8.3
Northern province	5.9

About 79% of the 376 women that used condom are in their 20s and 30s, however, a greater percentage (68.4%) of the women that never used condom are also in their 20s and 30s (not shown). It was confirmed in a study that most women are sexually active in their 20s and 30s (Worth, 1989), therefore most of the women in this sample could be considered to be at risk of STIs including HIV, as a result of not engaging in safer sex through condom use.

There are 64.4% Africans that used condom, 11.5% Coloureds, 16.8% whites and 7.2% of the Indians. More than 80% of those that practice safer sex reside in an urban area while only 16.8% live in a rural area. This means those women in the rural areas are more at risk of STIs. Ulin (1992:84) also points out that rural women are more at risk as a result of being increasingly recipients of the (HI) virus, through sexual transmission, from husbands returning from cities and casual partners.

Education is very important when it comes to female autonomy, as it empowers women (Jewkes, 2002:1425) thereby helping them to practice safer sex. According to Agha (1998:32), education has a direct influence on condom use. Also, she posits that women who are not economically vulnerable have greater ability to negotiate safer sex. In other words, women who do not depend on their partners as a result of being economically empowered would be able to negotiate safer sex better. The table shows that 72.3% of the women that used condom had secondary education, while only 1.6% of them had no education. One striking thing about the table is that 53.6% of the women that used condom are unemployed, which means they still managed to practice safer sex despite being unemployed. One would have thought fewer number of unemployed women would use condom, since they are probably depending on their partners for support (therefore they would not be able to practice safer sex). The reason why they were able to use condom might be as a result of being educated, since more than 50% of the women in the study have a secondary and higher education (table 5.3).

About 40% of the women that have never been married reported the use of condom while 30% of the married women have used it. This shows that there is a tendency for those who had never been married to use condom than those who are married. This might be due to unequal power relations in marital relationships as a result of patriarchy. Many of these women that used condoms had between 1-2 children (50.7) while only 30.1% that had no children did. About 41% of these women reside in Gauteng.

5.5 Results of logistic regression model of socio-demographic variables

In order to know the relationship between the socio-demographic characteristics of the women that experienced IPV and safer sex, a multivariate logistic regression was done, with condom use as the dependent variable. Table 4 below shows that there are 5 variables that are significant or that have influence on condom use. The model illustrates that age, race, residence, education and number of children have an effect on safer sex practice of women that reported IPV, controlling for the other variables.

Table 5.5: Logistic regression model of socio-demographic variables

Variable	Odds Ratio
Age	
(15-19)	1.00
20-24	2.284**
25-29	2.252**
30-34	2.260**
35-39	1.026
40-44	1.334
45-49	0.941
Race	
(Black/African)	1.00
Coloured	0.770
White	2.083**
Asian/Indian	3.238**
Residence	
(Urban)	1.00
Rural	0.539**
Education	
(No education)	1.00
Primary	1.169
Secondary	3.285**
Higher	7.486**
Number of children	
(No children)	1.00
1-2 children	0.592**
3-5 children	0.518**
>5 children	0.357
Note: Reference category in parenthesis. ** Significant at p< 0.01; *Significant at p< 0.05	

According to the model, women aged 20 – 34 are (more than) twice more likely to use condom than those between 15-19. This is not consistent with other studies (Agha, 1998:34; Soskolne et al., 1991:223), which revealed that younger women are more likely to use condom. The reason for more women aged 20-34 reporting condom use might be because they are more likely to report IPV in this study. However, the probability of practicing safer sex is greater for those in age

group 20-24, when compared to the other age groups. The Indians are thrice and whites are twice more likely to practice safer sex than Africans. This might be because they are more economically empowered than the Africans. Those in the rural areas are 46% less likely to practise safer sex than those in urban areas.

Education is a variable that has been pointed out in many studies as enhancing female autonomy (Jewkes, 2002; Coker and Richter, 1998), thereby helping a woman to practice safer sex. The table shows that those women with secondary education are 3 times more likely to use condom than those with no education. Also, those women with higher education are 7 times more likely to use condom than those with no education. This shows that education could help a woman to use condom.

Number of children is a demographic characteristic that has been associated with IPV because a large family is more likely to cause IPV (Jewkes, 2002: 1423), especially if the man is unemployed and the family lives in poverty. Due to unemployment (and poverty), a man with a large family might find it difficult to provide for his family thereby venting out his anger on his partner by assaulting her (Green, 1999). It is interesting to see that number of children also has an effect on the use of condom. Table 3 shows that women with children are less likely to practice safer sex than those who have no children. This might either be as a result of their partner's desire for children thereby making it difficult for them to negotiate for condom use. Some studies (Biddlecom and Fapohunda, 1998; Castle et al, 1999) have shown that if a man desires children the woman might not be able to practice safer sex.

5.6 Sexual behaviour

Previous studies (Varga, 1997; Soskolne, 1991; Agha, 1998) have shown that there is need to consider the sexual behaviour of women when focusing on condom use. This is because their sexual behaviour would determine whether they are more at risk of STIs and therefore would use condom. For instance, according to these studies (Varga, 1997:49; Soskolne, 1991; Agha, 1998) condom use is most likely in casual (non-marital) sexual relationships and least likely in marital relationships. This means sexual behaviour such as number of regular sex partners could determine condom use. As a result of this, some variables pertaining to sexual behaviour was examined in this section as well as their relationship with condom use.

Table 5. 6: Sexual behaviour variables

Variable	N (1386)	%
Number of regular sex partner		
No regular sex partner	866	62.5
1 & 2 regular sex partners	422	30.4
Occasional partner	98	7.1
Relationship to last sex partner		
Marital partner	535	38.6
Other partner	576	41.6
Casual acquaintance	92	6.6
Sex worker & other	183	13.2
Age at first intercourse		
Never had intercourse	25	1.8
9-13	57	4.1
14-18	940	67.8
19-23	272	19.6
24-28	22	1.6
At first union	49	2.1
No idea	41	3.0
Used condom last intercourse		
No	1234	89.0
Yes	152	11.0
Partner dislikes condom		
No	1033	74.5
Yes	353	25.5
Decision about method		
Respondent decides	347	25.0
Partner decides	69	5.0
Jointly	234	16.9
Other	736	53.1

Table 5.6 above presents the frequency of the sexual behaviour of women that experienced IPV. There are more women with 1 and 2 regular (non-marital) sex partners (30.4%) while only a few have occasional partners (7.1%). However, majority (62.5) of the women did not report having a regular partner. This is because it is difficult for women to report that they have more than one partner, since promiscuity is usually associated with women with multiple sex partners (Varga, 1997), which is not acceptable in most cultures. This therefore causes underreporting of number of sex partners.

About 38% of these women reported their marital partner as their last sex partner, 41.6% reported other (regular) partner, 13.2% had it with a sex worker and 6.6% had their last sex with a casual acquaintance.

Most of these women had their first intercourse between the ages of 14 – 18 (67.8%) while a few had it between the ages of 9 –13 (4.1%). This shows that most of these women were at risk of STI/HIV and unwanted pregnancy. According to the

1994 UNDP report, "a woman's probability of contracting HIV increases dramatically as her age at first intercourse goes down" (Radhakrishna et al as quoted in Manzini, 2001:45). Only 1.8% had never had an intercourse while 2.1% had their first sexual intercourse at first union. However, majority of these women (89%) did not use a condom at last sexual intercourse. One reason for this might be that their partner dislikes condom; almost 75% of them reported this.

The decision about whether to use contraception is very important when it comes to sexual behaviour as this can determine whether a woman would practice safer sex or not (Dixon-Mueller, 1993). According to Dixon-Mueller (1993:269), the extent to which a woman is able to negotiate the "terms of trade" of a sexual relationship would determine whether she would engage in safer sex practice. In other words, the ability of a woman to take decision about method of contraception in a relationship could determine condom use. It is therefore important to include the variable "decision about method' with other sexual behaviour variables.

Table 5.6 shows that only 25% of the women make the decision about using a method. However, for 16.9% of them, it is a joint decision, while 53.1% reported others as making the decision for them, probably their mothers or friends. Only a few (5%) reported that their partner makes this decision.

5.6.1 Sexual behaviour and condom use

Table 5.6b shows the relationship between sexual behaviour and the use of condom by the women that experienced IPV. There are more women that did not report number of regular sex partner that have used condom (55.6%). They probably used it with non- regular partners which they failed to report due to the reason that casual and multiple partners is not really acceptable for women in the society. About 36% of those that reported 1 and 2 (non-marital) regular partners used condom while only 8.5% of those that have occasional partners used it.

There are more women who reported other (regular) sex partner that used condom (45.6%) and this might be a result of women finding it easier to use condom with non-marital partners. About 38% of those that reported marital partner as their last sex partner used condom, 8.5% for those that reported casual acquaintance while 7.7% for those that reported a sex worker as their last partner. Most of the

women that had their first intercourse at ages 14 -18 (68.1%) had used condom while only 1.9% had used it at first union.

Table 5. 6b: Sexual behaviour and use of condom

Variable	Used condom (%) (n=376)
Number of regular sex partner	
No regular sex partner	55.6
1 & 2 regular sex partners	35.9
Occasional partner	8.5
Relationship to last sex partner	
Marital partner	38.1
Other partner	45.6
Casual acquaintance	8.5
Sex worker & other	7.7
Age at first intercourse	
Never had intercourse	0.0
9-13	3.5
14-18	68.1
19-23	23.1
24-28	0.8
At first union	1.9
No idea	2.7
Used condom last intercourse	
No	59.5
Yes	40.5
Partner dislikes condom	
No	88.8
Yes	11.2
Decision about method	
Respondent decides	22.2
Partner decides	3.2
Jointly	18.7
Other	55.9

For those women that did not use a condom at last intercourse, 59.5% of them reported having used it before. Surprisingly, about 88% of the women that have a partner that dislikes condom have used condom. This however might mean that they used it with casual rather than regular (marital) partners. Condom use is reportedly more common in casual relationships than in long –term committed relationships. This is because women are more able to negotiate for condom use in casual relationships (Soskolne et al., 1991; Varga, 1997). However, the table shows that only a few women reported occasional partner, probably due to under-reporting as a result of cultures that frown on women that have multiple (occasional) partners.

It is striking that most of the women (55.9%) that reported others making the decision for them about the use of a contraceptive method, have used condom. As aforementioned this might be their mothers or friends. If friends, that means that peer

influence can help women to use condoms. However, studies (Varga, 1999; Wood et al., 1998) in South Africa have shown that peer influence has a negative impact on safer sex practice.

5.7 Results of the logistic regression model of sexual behaviour

Table 5.7 shows that there are only two variables, that is, number of regular sex partner and partner dislikes condom that are significant, controlling for the other variables. It is surprising the other variables like age at first intercourse and condom use at last intercourse are not significant, and therefore cannot be considered to have an effect on condom use for women that reported IPV.

Table 5. 7: Logistic regression model of sexual behaviour

Variable	Odds Ratio
Number of regular sex partner	
(No regular sex partner)	1.00
1 & 2 regular sex partners	1.566**
Occasional partner	1.409
Partner dislikes condom	
(No)	1.00
Yes	0.279**
Note: Reference category in parenthesis. **significant at p< 0.01; *significant at p< 0.05.	

Those women with 1 & 2 regular (non-marital) sex partners are more likely to use condom than those with no regular partner. This is consistent with the studies (Soskolne et al., 1991; Agha, 1998) that show women are more likely to use condom with non-marital partners. However, the variable, occasional partner has no significant effect on condom use. For those that have partners that dislike condom, they are less likely to practise safer sex through the use of condom. One implication of this is that the women will be more vulnerable to the risk of contracting sexually transmitted infections and unwanted pregnancy, as it has been confirmed in previous studies (Wood and Jewkes, 1997; Worth, 1989) because women generally do not have a say in sexual matters.

5.8 Partner's background characteristics

Next to be considered is the effect of the women's partner's background characteristics on the use of condom. This is important, as it has been indicated in some research (Agha, 1998; Adetunji, 2000) that partner's characteristics such as

age and education could determine whether or not a woman would practice safer sex. Table 5.8 presents three variables that were considered in this section.

Table 5. 8: Partner's background characteristics

Variables	N	%
Partner's age		
18-32	185	13.4
33-47	365	26.3
48-60	82	5.9
>60	44	3.2
Total	**676**	**48.8**
Partner's education		
No education	79	5.7
Primary	252	18.2
Secondary	438	31.6
Higher	69	5.0
Total	**838**	**60.5**
Partner's occupation		
Professional	54	3.9
Clerical	30	2.2
Sales & Services	155	11.2
Skilled manual	283	20.4
Unskilled manual	307	22.1
Total	**829**	**59.9**

Only 676 (48.8%) women reported their partner's age; most (26.3%) of these partners are between age group 33-47, 13.4% have partners aged 18-32, 5.9% have partners aged 48-60 while only 3.2% have partners that are older than 60 years. For education, only 838 (60.5%) women reported the educational status of their partners. Most of the women have partners that are educated. About 37% of the women's partners have a secondary and higher education, while 5.7% have no education. Also for their partner's occupation, not all the women were able to report this. Out of 829 (59.9%) that reported, 22% reported that their partners are involved in unskilled manual, 20.4% in skilled manual, 11.2% in sales and services while only 6.1% in professional and clerical jobs. None of the women reported that their partner is unemployed. The under-reporting of partner's characteristics might be due to communication gap between the women and their partners, probably as a result of IPV.

5.9 Results of the logistic regression model of partner's characteristics

The results of the logistic regression model for partner's characteristics (table 5.8) revealed that two out of these variables identified, that is, partner's age and education that have an effect on condom use. The table shows that the odds of women using condom decreases as partner's age increases. Women with older

partners are less likely to practise safer sex. According to Radhakrishna et al (cited in Manzini, 2001:45), most young women are likely to be having unprotected sex with men older than themselves, who have longer sexual histories. The findings from this model suggest the women probably have older partners and therefore they were not able to negotiate for condom use due to their powerlessness in the relationship. Those with partners aged 33-47 are 35% less likely to use condom than those with younger partners. Also those that have partners aged 48 and above, are (about) 70% less likely to engage in safer sex practice than those with partners aged 18-32.

Table 5.9: Logistic regression model of partner's characteristics

Variable	Odds ratio
Partner's age	
(18-32)	1.00
33-47	0.648*
48-60	0.272**
>60	0.245*
Partner's education	
(No education)	1.00
Primary	1.156
Secondary	3.809**
Higher	18.908**

Note: Reference category in parenthesis. ** Significant at p< 0.01; *Significant at p< 0.05.

Those having partners with secondary and higher education are more likely to use condom than those with no education. It is striking (although not really surprising) that women that have partners with secondary education are thrice more likely to use condom than those with no education and those women with partners that have higher education are almost 19 times more likely to use condom than those with no education. This shows that partner's education plays a major role in condom use among women.

The results of this model are consistent with studies (Agha, 1998; Adetunji, 2000) on condom use among men, which show that younger and educated men are more likely to use condom with their partners. This of course means that their women practice safer sex, which is also the same in this study (as it is male condom that was used). In other words, since the partners of these women (in this study) used condom, they were also protected.

5.10 The relationship between IPV and condom use

So far in this study, the relationship between the characteristics of women that reported IPV and condom use have been examined; the results show that most of the characteristics have a relationship with condom use. However, there is still the need to know the relationship between IPV and condom use, which is examined in this section.

In order to examine the relationship between the two, a bivariate logistic regression was done, with condom use as the dependent variable. Table 5.10 shows that it is less likely for women that reported IPV to practise safer sex. In other words, the probability of using a condom is lesser for a woman that reported IPV in her relationship than for those that never reported it. This therefore means that IPV hinders safer sex practice among women, which is consistent with other studies (Coker and Richter, 1998; Varga and Makubalo, 1996).

Table 5.10: Bivariate logistic regression of IPV and condom use

Variable	Odds Ratio
Intimate Partner Violence	
(No)	1.00
Yes	0.371**
Note: Reference category in parenthesis. ** Significant at p< 0.01; *significant at p< 0.05.	

5.11 Discussion of major findings

The aim of this study was to examine whether intimate partner violence (IPV) is an obstacle to safer sex practice. The findings from the regression analysis revealed that women that reported IPV are less likely to practice safer sex with their partners.

The results from the models used to examine the relationship between intimate partner violence and condom use, revealed that that there is a causal link between the two events. It is quite interesting to see that results are quite similar to those in previous studies (Agha, 1998; Coker and Richter, 1998), even though most of them either focused only (either) on intimate partner violence or condom use. It is also striking to see that some characteristics (or variables) that have effect either only on intimate partner violence or condom use in some studies could also be linked to the causal relationship between the two in this present study. Only a few studies in Africa have used regression analysis to examine the causal relationship between

intimate partner violence and condom use; hence this study contributes to the limited research on intimate partner violence and condom use in Africa.

The first model considered in this study, shows the relationship between the socio-demographic characteristics of women that experienced IPV and condom use. Age, which is one of the characteristics, has been found occasionally to be a risk factor for IPV and a predictor of condom use (Jewkes, 2002:1423; Agha, 1998: 34). This model revealed that older women are twice more likely to report condom use than those aged 15-19. This is contrary to other findings from studies (Agha, 1998:34; Soskolne et al., 1991:223), which revealed that younger women are more likely to report condom use. One reason for this might be because there were more older women that reported IPV in the survey hence resulting in more of them also reporting condom use.

The other characteristics that are significant include race, residence, number of children, as well as education. It was found that Indian and white women are more likely to report condom use than African women, which might be due to their economic empowerment. Even though the patriarchal system creates unequal power relations among partners thereby making women to be powerless in sexual decision-making. Orubuloye et al. (1993) point out that women who are economically empowered can still exercise some rights over sexual decision making.

It was also found that women in the rural areas are less likely to report condom use, probably because they are less empowered than their counterparts in the urban areas. And as a result of patriarchy they are unable to make decision pertaining to sexual matters, and therefore unable to negotiate for safer sex.

The socio-demographic model also revealed that women with children are less likely to use condom. One reason for this might be that their partners did not consider condom as a method to be used for family planning in stable relationships. According to Maharaj (2001:252), even though male condom was recognised as a method of preventing unwanted pregnancy and STIs by men in a study, they preferred not to use it in a stable relationship. This was as a result of a strong association in the men's mind that condom use implied lack of trust (Maharaj, 2001:253).

Education and occupation were included in the model in order to examine the relationship between socio-economic status and condom use. It was found that due to the collinearity between education and occupation, only education was significantly related to the other characteristics. The model revealed that women with secondary

and higher education are more likely to use condom. A bivariate regression analysis of occupation and condom use (not shown) was done and it revealed that occupation also has an effect on condom use, controlling for the other characteristics. This means that education and occupation (independently) have an effect on condom use. The findings are therefore consistent with the hypothesis that the higher the socio-economic status of women (that experienced IPV), the greater the likelihood of safer sex practice.

The next to be examined was the sexual behaviour model, which could be considered to be very important when considering safer sex practice. The following variables were included in the model: number of regular sex partner, relationship to last sex partner, age at first intercourse, used condom last intercourse, partner dislikes condom, decision about method and number of unions. Only two of these have a significant effect on the condom use of women that experienced IPV.

According to the sexual behaviour model, only the variables, number of sex partner and partner dislikes condom have a significant effect on safer sex practise of women that have experienced IPV. The model revealed that, women with 1 & 2 (non-marital) regular partners are more likely to use condom than those with no non-marital partner. This finding is consistent with another study that also revealed that women with multiple partners were more likely to use condoms (Soskolne et al, 1991:223). One reason that could be given for the use of condoms by women with these partners might be that women find it easier to negotiate safer sex practise with non-marital partners than with marital partner (Agha, 1998:36).

The other significant variable, partner dislikes condom, shows that women that have experienced IPV are less likely to use condom if their partner dislikes. This might be due to the inability of the woman to negotiate safer sex practise especially due to patriarchy that makes a woman powerless in a relationship. According to Maharaj (2001:252), men wield enormous power over sexual decision-making as a result of this, men in the study felt condom use were their prerogative. In other words, due to patriarchy men control sexual decision-making and any decision they make will be in their favour. If they do not like using condom then the women (partners) would not be able to practise safer sex. The finding of the study by Maharaj (2001) is therefore consistent with this present study.

In order to examine the effect of partner's background characteristics on the use of condom by women who reported IPV, a model, combining partner's age,

education and occupation was used. The findings revealed that women with partners aged 48-60 are less likely to use condom than those with younger partners. Also, those with partners that have secondary and higher education are more likely to use condom. This is consistent with findings from a research that reveals men are more likely to use condom if educated, which of course means that their partners (women) practice safe sex (Agha, 1998).

The last model, which is a bivariate regression analysis of intimate partner violence and condom use, revealed that the probability of using a condom is lesser for women that reported IPV than those who never experienced (nor reported) it. This is line with the hypothesis that says IPV reduces the likelihood of safer sex practice among women. It was also found in another research (according to Moore, 1999:304) that abused women are less likely to report condom use. This study therefore confirms that IPV is an obstacle to safer sex practice in South Africa.

In sum, the findings in this study suggest that IPV is a factor that needs to be taken into consideration if safer sex practice is to be encouraged among women. One of the reasons why women find it difficult to practice safer sex in a relationship where IPV is present is due to unequal power relation (Blanc, 2001) enhanced by the patriarchal system in the society that makes women to be powerless. The patriarchal system not only dominates, but also oppresses and exploits women (Walby, 1990).

In order to examine how men dominate, oppress and exploit women due to patriarchy in the society, the next chapter presents some case studies. These case studies give more insights into experiences of IPV by women, which could not be obtained from the (reported) data used in the quantitative analysis.

Chapter 6

Analysis of case studies of women that experienced IPV

This study has so far considered the causal relationship between intimate partner violence and safer sex practice (condom use) through the use of logistic regression analysis. However, there is still the need for an intimate knowledge of not only the experiences of IPV by women but also how it could prevent safer sex practice. This chapter presents the analysis of case studies of women's experiences of IPV in their relationships.

Apart from understanding their experiences, the case study analysis examines the effects of some characteristics (such as socio-economic characteristics and sexual behaviour) on intimate partner violence. Findings from the quantitative analysis revealed that education (and also occupation) has an effect on condom use. That is, women with high socio-economic status are more likely to practise safer sex? However, would high socio-economic status lessen the chance of women experiencing IPV? In order to answer this question as well as some other (research) questions highlighted at the beginning of this discourse, some case studies were analysed.

As a result of time and space constraints, only one case study is given in detail while the other case studies are summarized. The main case study is presented below while the others would be drawn upon to illustrate particular findings.

6.1 Main case study

Irene[6] story begins just 6 months after her 16th birthday. After a short relationship she found herself married to what she thought to be a very tall dark and handsome man. The eve of her wedding day should have triggered some warning bells when she was trying to alter the hem of a wedding dress that she was meant to wear the next day. A sharp slap in the face from her fiancé told her he was angry with her for not doing the sewing job properly. She was stunned; he hastily apologized and said that she should return the blow.

A brief account of her background would help to explain her shock at this sort of physical abuse. They were a family of four sisters who lived with their grandmother as caregiver and mother as breadwinner. Not one of the sisters could ever remember having a father firstly, and secondly, no male visiting their mother had ever used violence or had ever imposed his will on her. Irene believed she had left an unhappy and impoverished home with the hope of a loving relationship and a brighter future.

One year after being married she gave birth to a son. She had worked until 4 days before his birth and was eager to return to work. Prior to terminating her employment her husband

[6] Pseudonym

began making demands on her salary and insisted on every cent of it to pay off their debts. It was not long after that he started a new job that she discovered he was seeing someone who was still in school, (where she too should have still been) and this other woman was living near his place of employment. Irene confronted him about the affair and found herself (not for the first time in the marriage) with chunks of hair missing and a dislocated lower jaw. She realised she had to take control of her reproductive well being and keep her wits about her if she wanted to survive. Her husband discovered that his girlfriend was also seeing someone else at the same time as she was seeing him, which further infuriated him as he felt, betrayed and hated being 'two-timed'.

Irene began working again when her son was 5 months old. She had often tried to discuss family planning with her husband and he said he did not want to use contraceptives. Instead of the discussion being about preventing another birth, which they could ill afford, it became a war as he insisted she wanted contraception because she was seeing someone else. Eventually it would become a fight so she left it at that and hoped she would not fall pregnant. Sex was an every night occurrence without fail, if she dared say no or tried an excuse she would be faced with accusations which always landed up with heavy sarcasm and usually ended with all night psychological abuse that she had probably had "it" elsewhere already. Her life was a misery as he continued with his girlfriend and often brought her to their flat where she had to serve food and drinks.

Irene's new job at a Building Society opened a few new doors for her; one was a girl who was about to go on maternity leave. Somehow, she understood her plight and without too many explanations, let her have her remaining 3 months supply of her oral contraceptive. After that she found a family planning clinic near to her place of work and rushed down every 3 months during lunch time to collect her supply.

She had a secret place in her handbag where she could hide the pills as her husband regularly threw all her 'junk' out of her handbag as he went through it. After many more turbulent months in her life, when her son was just about a year she tried to leave her husband. One of the reasons was that while she was at work and on weekends he began physically abusing their son.

She managed to stay with her sister for a while but he soon found her and promised that all would be okay and he would never lift a hand to her again. She believed him and meekly went back only to discover nothing had changed. While away from him she had stopped taking the pill so of course, when she was reunited, she immediately fell pregnant again. He was delighted at having a girl this time and Irene thought he would now be happy with his family. The violence continued however and now he held the children as hostages if she indicated that she might leave.

After their daughter was about two he discovered he had viral warts and had to have them removed. She was ignorant at the time and did not know that they were indications of STIs. She thought she should be grateful that whatever STI he had picked up did not affect her. He later moved to a new job and met another young woman who was unaware that he was married. At this stage, she had negotiated the use of the oral contraceptive but talk of condoms was never mentioned, as she knew what the result of that would be. The new girl friend was an educated woman and decided after meeting her and the children not to see him again. No doubt Irene felt his wrath because she had interfered in his life. The story continued for thirteen bitter years, but for the purpose of this study it would be cut short.

The case study above illustrates how difficult it is for a woman that is experiencing IPV to practice safer sex. Not only does she find it almost impossible to negotiate safer sex but also she lives in fear of discovery if she managed to do it. This is also consistent with some studies which revealed that women find it difficult to use contraceptives, and those that use them secretly, live in fear of discovery as it can result in conflict between partners (Biddlecom and Fapohunda, 1998: 370; Castle et al., 1999: 242), which could lead to IPV.

The case study also shows the different forms of IPV that a woman could go through. Irene experienced physical, financial and emotional abuse at the same time. Irene's husband not only hit her but also she was forced to have sex with him every day. Also, she was emotionally abused when her husband continued to bring his girlfriend to their home and she had to serve food and drinks. This means a woman can experience different forms of IPV at the same time. Even if she managed to leave the relationship like Irene did; she might still find herself back in the cycle of violence due to 'love', her children and economic dependence (if dependent on the man for survival). Irene tried (again) to leave her husband after having the second child but she could not, because her children were now held as hostages. Irene did not want to leave her children so she continued to stay with him despite the violence.

Irene was also exposed to the risk of contracting sexually transmitted infections due to the failure of her husband to use condom with her (and probably with other partners). She wanted to talk to him about using condom but she perceived that the result would be more abuse. Some studies (Ulin 1992; Worth, 1989) also revealed that women might not be able to demand the use of condom if it "could result in powerful negative reinforcement with more frightening repercussions than the long-range threat of disease" (Ulin, 1992:68). In other words, a woman in an abusive relationship might consider it is better for her not to talk about condom use rather than exposing herself to abuse. Hence, she thinks more about the present (abuse) than the future (HIV).

According to Blanc (2001:190), gender –based power relations (unequal power relations) has a direct effect on the ability (of a woman) to take action to protect herself. "Direct effects include, for example, the influence of power imbalances on women's ability to negotiate condom use with their partners" (Blanc, 2001:190). In other words, unequal power relations due to patriarchy makes women not only to be abused but also find it difficult for women to negotiate condom use even though they might be aware of the consequences of not using it.

One other striking thing about Irene's story is that, even though she managed to use pills (to prevent pregnancy) she could still have contracted STIs and even HIV. In order words, condom use, which offers dual protection would have been better, however due to her inability to negotiate safer sex with her partner she was unable to get dual protection from condom use. This shows that as a result of IPV it is difficult for a woman to communicate her reproductive health need preferences to her

partner. According to Blanc (2001: 194), spousal communication is associated with greater contraceptive use. In other words, lack of communication between partners could negatively affect the use of contraceptives by a woman, thereby making a woman to be unprotected.

Partner (spousal) communication is posited in many studies on family planning as a way in which greater contraceptive use could be achieved among partners (Blanc, 2001:194). These studies also show that due to poor communication between partners, women are unable to express their desires and fears (about sexual matters) to their men (Blanc, 2001:194) thereby they could not engage in safer sex. According to Irene, she wanted to protect herself but found it difficult to talk to her spouse about it. Sometimes women who suggest condom use may be accused of infidelity. At the same time he was having an affair and even contracted an STI, which could have been transmitted to Irene (fortunately she did not get it). According to Blanc (2001:194), "women are expected to be passive in sexual matters... and those who raise the topic with their husbands may be perceived as promiscuous", especially when IPV is present in a relationship, as in Irene's case. Considering this fact, it could therefore be deduced that IPV not only hinders the negotiation of safer sex between partners but also enhances the spread of STIs including HIV/AIDS. This has also been confirmed in other studies (Jewkes et al,1999; Wood and Jewkes, 1995;Varga, 1997).

One of the ways in which a woman can contract STIs is through rape or sexual abuse. In some of the case studies, the women reported how their partner either raped or forced himself on them. Women who are forced to have sex do not have the power to negotiate safer sex. The case study below shows how sexual intercourse could be spontaneous, leaving no time for a woman to negotiate or practice safer sex.

> *Dudu[7], a young woman, had only been in a relationship with her boyfriend for less than a year. Due to an argument they had, when her boyfriend visited her, she refused to open the door. He however told her that he was thirsty and needed to drink water. She let him in but when he got inside, he started kissing and fondling her. She therefore asked him to leave. He was infuriated and raped her.*

[7] Pseudonym

The case story above illustrates the fact that Dudu was in no position to negotiate safer sex since her boy friend raped her to punish her and also to assert his dominance over her. The need to assert his dominance over his partner is due to the patriarchal system in the society that dominates, oppresses and exploits women (Walby, 1990). In Dudu's case, her partner raped her in order to reaffirm his manhood.

Dudu's case also shows how sex (or rape) could be spontaneous. Her partner would not have thought of using a condom to protect her or himself since he was irrational. He therefore exposed himself and especially Dudu to the danger of STI/HIV and IPV. According to Worth (1989:304), condom use has to be renegotiated with every contact (assuming the couple has been using it). Since it is always the woman that is encouraged to ask a male partner to use a condom, she is more vulnerable to IPV if she asked him for condom use. Worth (1989: 305) also posits that if a woman is in an abusive (intimate) relationship, mentioning condom can expose her to abuse. The next case study also presents the inability of a woman to negotiate safer sex practice in an abusive relationship.

> *Ayanda[8] had only lived with her boyfriend for a month when the abuse started. Her boyfriend wanted to burn her clothes because he suspected that she had another boyfriend. He was addicted to alcohol and used to hit her, making sure no mark was upon her body. He wanted her to be at his beck and call. He was always angry whenever she forgot to call him from work. He refused to allow her to visit her family. One day, he wanted her to perform oral sex with him, but she refused. Angrily, he forced himself on her.*

Ayanda must have found it difficult to ask someone that forced himself on her, to use a condom. This case study and the others therefore point out the danger of IPV in a relationship. Not only is a woman sexually abused but also emotionally abused especially if she does not want sex since she is being degraded as a result of not having power over her body. In Ayanda's case her partner wanted her to do something she was not comfortable with and instead of accepting her refusal, he forced himself on her. Other studies have also revealed how women find it impossible to refuse their partners. A woman in one of the studies made a remark that "a woman is not free and she is therefore not the owner of herself" (Van de Walle and Ouaidou, 1985 cited in Dixon-Mueller, 1993:271). This suggests that in an

[8] Pseudonym

abusive intimate relationship, a man can do whatever he pleases with a woman' s body especially by degrading her as a result of her powerlessness in a patriarchal society. There is therefore the need for the problem of IPV to be addressed in our society.

In order to address the problem of IPV, female empowerment is usually considered as the way out. According to Jewkes (2002:1425), "high levels of female empowerment seem to be protective against IPV, ... in many studies, high educational attainment of women was associated with low levels of violence". However, the case studies in this study revealed that women irrespective of their socio-economic status experience IPV. This is illustrated in the following case study.

> *Geeta*[9] *was a teacher with university degree and had been married for 8 years. However she had suffered physical abuse in half of the period. Her husband used to abuse alcohol and extremely abusive over the weekends. Her husband did crazy things when under the influence of alcohol. She had to pay the bills since he preferred spending his money on alcohol.*

Similarly, Krishnee[10]another woman experienced IPV despite the fact that she was educated.

> *Krishnee was a beauty therapist with a matric. She had been in a relationship for almost 3 years. The abuse started when he found out that she was pregnant with his child. At first, he wanted nothing to do with the child, however when the baby was born, he tried to take the baby from her. He abused her almost every day. He even refused to provide money for child maintenance.*

The two cases of Geeta and Krishnee show that socio-economic status does not in any way prevent IPV. This therefore answers the question that high level of socio-economic status does not lessen a woman's chance of being abused. However it can help a woman to know and take the right steps in finding a way out since she is enlightened. Most of the women took an interdict to protect them from their partners, which is a step in the right direction.

6.2 Discussion

The purpose of this study was to examine how intimate partner violence could serve as an obstacle to safer sex practice. The case studies highlighted in this section have shown that IPV is indeed an obstacle to safer sex practice. Not only did

[9] Pseudonym

women find it difficult to communicate with their partners the need for safer sex, but also they were vulnerable to the contraction of STIs including HIV. This also shows that women lack the power to make decision pertaining to sexual matters. And one reason for this is the system of patriarchy that is embedded in our society. The system of patriarchy not only dominates women but also exploits them. This is demonstrated in Irene's case; her husband not only forced her to have sex with him every day but he also refused to use a condom. Also he brought his girlfriend in to their matrimonial home. Patriarchy therefore creates the atmosphere for intimate partner violence, which is an obstacle to safer sex practice.

Women's empowerment through solidarity and social support is one of the ways, in which the effect of patriarchy on women could be reduced (Orubuloye et al 1993; Ulin, 1992). Ulin (1992: 67) points out that through informal associations and networking, African women have been able to rally behind each other to solve numerous common problems. In other words, if women can come together through informal associations and community activities, they will be able to overcome IPV. Jewkes (2002) also believes that social support is a source of power for women. According to her (Jewkes, 2002:1425), "women who have respect and power outside the home through community activities, including participation in micro credit schemes, are less likely to be abused than those who do not". There is therefore the need for such programs like micro credit scheme that can empower women thereby reducing IPV in our society.

Even though these case studies show that high socio-economic status or female empowerment through education does not protect women against IPV, empowerment as a way out for women should not be ruled out. This is because empowerment through informal associations and social support can help to reduce IPV as aforementioned. And also how a woman uses her empowerment is what will determine whether she can escape IPV in her relationship. According to Orubuloye et al. (1993:861), studies in West Africa show that women's autonomy (empowerment) rests on their ability to trade. In one study by Orubuloye et al (1993) in Nigeria, it was revealed that Yoruba women of Ado-Ekiti have more autonomy because they engage in trade and also control their earnings. As a result of this, the women have more control over their sexuality. Even though a woman can refuse her husband sex, no

[10] Pseudonym

case of IPV was reported in this study. This study therefore shows that a woman can practice safer sex if she has control over her sexuality. In order to further show how women can gain control over their sexuality and hence prevent IPV, the next chapter present some recommendations.

Chapter 7

Conclusion and recommendations

The main purpose of this study was to examine how intimate partner violence serves as an obstacle to safer sex practice among women. Findings from this study have highlighted the relationship between intimate partner violence (IPV) and condom use. This study therefore contributes to the limited research on IPV and condom use. In this chapter, a summary of major findings from both the quantitative and qualitative analyses would first be presented and then some recommendations would be suggested on how the problem of IPV should be tackled in our society.

7.1 Summary of major findings from triangulation method

The findings from the triangulation method, that is, quantitative and qualitative analyses revealed that there is a relationship between IPV and safer sex practice, which is condom use in this case. The quantitative analysis, through the use of logistic regression models, revealed that women who experienced IPV are less likely to use a condom, while the qualitative analysis, through some case studies, showed how a woman could find it difficult to ask her partner to practice safer sex.

The two methods also complement each other by showing that it is difficult for a woman who reports or experiences IPV to negotiate condom use with her partner. This therefore makes the woman to be at risk of unwanted pregnancy and STIs including HIV. One factor that was linked to the inability of women to negotiate safer sex in a relationship is lack of control or power over decision-making, made possible by the patriarchal system in the society. In other words, patriarchy makes women to be powerless to negotiate safer sex in their relationship.

Other findings from the quantitative analysis revealed that high socio-economic status could help a woman to use a condom. However, the qualitative analysis revealed that not only can a woman experience IPV irrespective of her socio-economic status, but also she can find it difficult to practice safer sex. The case studies (used in the qualitative analysis) showed that any woman could experience IPV, whether she is educated or not. Even though her education can help her to know about safer sex, she however might not be able to practice it if IPV is present in her relationship. This therefore means that there is still the need to find a way in

which women's empowerment can help to solve the problem of IPV in South Africa. Suggestions on how this could be achieved would be discussed in the next section.

Other major findings from the quantitative analysis revealed that sexual behavior has an effect on condom use. It was found that women with 1 or 2 regular (non-marital) partners are more likely to use condom than those with no regular partners. This is consistent with findings from other studies that have revealed that women are more likely to use condom in non-marital relationships than in marital relationships (Agha, 1998:36; Soskolne, 1991:223). It is therefore good to note this when considering condom use among women.

Findings from both the quantitative and qualitative analyses revealed that a woman is less likely to practice safer sex if her partner dislikes condom. Women are not able to insist on condom use because negotiating safer sex could also make them to be at risk of further IPV (Worth, 1989:305). It is therefore necessary to also target men in order to address the need for safer sex practice.

Other findings from the quantitative analysis revealed that partner's age and education have an effect on women's condom use. Women with older partners are less likely to use condom while those with educated partners are more likely to use condom. Education should be considered as an important factor that could help men to understand the need for safer sex practice and which of course will help their partners (women) as well to engage in safer sex practice.

Next to be considered are some recommendations for addressing the IPV in our society.

7.2 Recommendations

Considering all these findings (in this study) that showed how IPV is an obstacle to safer sex practice, it is obvious that there is need to address the problem of intimate partner violence in South Africa. The study not only points out that women experiencing IPV are unable to practice safer sex, but also that they are at risk of contracting STIs including HIV. However, due to the limitation of this study (as a result of using only secondary data), one could not deduce how IPV could enhance HIV/AIDS in South Africa. Future research that uses primary data is needed to explore the link between IPV and HIV/AIDS in South Africa.

In order to address the problem of IPV and condom use, there is need for programs that target both men and women, and not women only, as this is what happens in many cases. Intimate partner violence should not be made a woman's problem. There should be more programs that reach out to men in order to make them know that IPV should not be a way for them to show their masculinity in a patriarchal society. Also, that every woman deserves to be respected and has the right to say no to what she does not want.

Even though men are now being targeted, there is need for such programs to "recognize that changing the norms and values of relationships from those of control and dominance (patriarchy) to those based on mutual respect and equity requires not only individual but also structural change" (Garcia-Moreno, 1999).

Garcia-Moreno (1999) also believes that men should not only be targeted but also be involved in addressing violence against women. She however gives a caution that resources should be allocated in a way that they are not diverted from the hard-won program efforts of women's organizations (Garcia-Moreno, 1999).

Women, especially adolescents, must be taught, through intervention programs, how they can make men to respect them. A young woman does not have to get involved with a man because all her friends are doing the same thing. Also, beating should never be considered by a woman as a way by which a man shows love to her as it has been confirmed in previous studies in South Africa (Dixon-Mueller, 1993:275; Rachel Jewkes et al, 1999:8; Kim and Motsei, 2002).

Even though the case studies revealed that women experience IPV irrespective of their socio-economic status, empowerment is still a way out, if they can learn to be assertive. However, this might only work for those that are not in a marital relationship. A woman (unmarried) that is economically empowered, whether educated or not, should not allow herself to be abused. If she notes her partner to be abusive, she must not turn a blind eye like Krishnee[11] did when her partner started abusing her after impregnating her. Right from the beginning of a relationship, a woman must make it clear that IPV is not acceptable in the relationship. If not, she might become one of the victims of IPV. There is however the need for women in South African to be assertive especially if they are economically empowered.

[11] Page 59

Empowerment through social support is also important. Women in a community must learn to support each other in order to overcome IPV. Women must not only talk about how to put a stop to IPV but also they must do practical things by supporting someone who is in need (as a result of IPV) by providing shelter and looking after her children until she sorts herself out (Speak, 1988).

Empowerment could also be achieved through intervention programs such as health-information campaigns that inform women of their rights, about the law and how health services can help them (Jewkes, 2002). However, there is still the need for health-sector staff to learn more about IPV and also to be equipped to handle it (Jewkes, 2002). Garcia-Moreno (1999) also posits that there should be training on how to address violence against women in institutions such as the police, the legal and health systems as those in the system may lack basic knowledge, time or empathy. They also may not know what to do, as some may be experiencing violence [or perpetrators of IPV] (Garcia-Moreno, 1999).

Empowering women (and girls) could also be done by improving the level of female education and providing more opportunities for women's employment and access to credit (Jewkes, 2002). This will go a long way in helping women to be less dependent on men and therefore they will be able to say no to any sexual demand they do not want. However, as aforementioned they need to be assertive in order to achieve this.

Even though the incidence of IPV is high in South Africa, it is good to note that it is not only the non-governmental organisations (NGOs) that is waging a war against it, but also the government. According to Jackson (1997), the Prevention of Family Violence Act of 1993 of South Africa was recently amended to deal more effectively with support for victims. The Act "enables women to interdict abusive partners from having contact with them for a specified period of time, without having to go through a lengthy and often costly process, as in the past" (Jackson, 1997).

Although there is still a long way to go before the Act and the prevention/ intervention programs (on violence against woman) can have impact on IPV in South Africa, the fact that the government is leading the way in the war against violence against women means that there is bound to be victory on the long run. For instance, the government led the way in the recent declaration of zero tolerance against violence against women for 16 days. This declaration was covered by both the print and electronic media, thereby making more and more people to be aware of it and

also to know that violence against women (including IPV) would no longer be tolerated in South Africa.

In sum, due to recent initiatives to address violence against women (including IPV) in South Africa, there is hope that with time it will also help in enhancing safer sex practice among women, as this study as proved that indeed IPV is an obstacle to safer sex practice.

Bibliography

Abrahams Naeemah, Jewkes Rachel and Laubsher Ria, 1999. "I do not believe in democracy in the home" Men's relationships with and abuse of women. **Medical Research Council Report**.

Adetunji Jacob, 2000. "Condom use in marital and non-marital relationships in Zimbabwe. **International Family Planning Perspectives**, vol. 6, no. 4: 196-200. **Africa.**

Agha Sohail, 1998. "Sexual activity and condom use in Lusaka, Zambia". **International Family Planning Perspectives**, vol. 24, no. 1: 32-37.

AIDS Action, 1999. "Talking about safer sex". Issue 45, July-September. Healthlink.

Biddlecom A.E. and B. M. Fapohunda, 1998. "Covert contraceptive use: Prevalence, motivations and consequences. **Studies in Family Planning**, 29, 4: 360 –372.

Blanc Ann, 2001. "The effect of power in sexual relationships on sexual and reproductive health: An examination of the evidence". **Studies in Family Planning**, Vol. 32, no.3.

Campbell Oona, Cleland John, Collumbien Martine and Southwick Karen, 1999. **Social science method for research on reproductive health**. World Health Organisation.

Castle Sarah, Mamadou Kani Konate, Priscilla R. Ulin, and Sarah Martin, 1999. "A qualitative study of clandestine contraceptive use in urban Mali". **Studies in Family Planning**, 30, 3: 231-248.

Coker Ann and Richter Donna, 1998. "Violence against women in Sierra Leone: Frequency and correlates of intimate partner violence and forced sexual intercourse". **African Journal of Reproductive Health**, Vol.2 no.1 : 61 -72.

Corbin William Jeffrey A. Bernat, Karen S. Calhoun, Lily D. McNair and Kari L. Seals, 2001. "The role of alcohol expectancies and alcohol consumption among victimized and non-victimized college women". **Journal of Interpersonal Violence**, vol.16, no. 4. Sage Publications.

Coward Rosalind, 1983. **Patriarchal Precedents: sexuality and social relations**. Routledge and Kegan Paul Ltd.

DeKeseredy Walter and Schwartz Martin, 1998. **Woman abuse on campus: Results from the Canadian National Survey**. Sage Publications.

Department of Health, Medical Research Council and Macro International, 2002. **South Africa Demographic and Health Survey (1998) Full Report**.

Dixon-Mueller Ruth, 1993. "The sexuality connection in reproductive health". **Studies in Family Planning**, vol. 24, no. 5:269-282..

Forbes Gordon and Adams-Curtis Leah, 2001. "Experience with sexual coercion in college males and females: role of family conflict, sexual attitudes, acceptance of rape myths, self-esteem and the big five-personality factors. **Journal of Interpersonal violence**, vol.16, no. 9. Sage Publications

Garcia-Moreno Claudia, 1999. "Violence against women, gender and health equity", a paper prepared under Global Health Equity Initiative project on "Gender and Health Equity" based at the Harvard Center for Population and Development Studies. http://www.hsph.harvard.edu/grhf/Hupapers/gender/garcia.html

Gelmon Lawrence and Piot Peter, 1996. "The interactions between HIV and other sexually transmitted infections" in Jonathan M. Mann and Daniel J. Tarantola (eds), **AIDS in the world II – Global dimensions, social roots and responses: the global AIDS policy coalition**. Oxford University Press.

Gordon Peter and Crehan Kate, 2002. Gender and the HIV Epidemic: "Dying of sadness, sexual violence and the HIV epidemic in Gender and the HIV epidemic". http://www.undp.org/hiv/publications/gender.violence.htm

Green December, 1999. **Gender Violence in Africa: African women's responses**. Macmillan Press Ltd.

Hair (Jr.) Joseph, Rolph E. Anderson, Ronald L. Tatham and William C. Black, 1998. **Multivariate data analysis**. Prentice Hall, New Jersey (Fifth Edition).

Heise Lori, Raikes Alanagh, Watts Charlotte and Zwi Anthony, 1994. "Violence against women: a neglected public health issue in less developed countries". **Social Science Medicine**, vol.39, No. 9: 1165-1179.

Jackson Louise, 1997. "Recent initiatives in addressing gender violence in South Africa'. Occasional paper No. 14. Crime and Policing Policy Project, Institute for Security Studies.

Jewkes Rachel,1999. "The impact of violence against women on sexual and reproductive health". **International Planned Parenthood Federation**. www.ippf.org/resource/gbv/chogm99/jewkes.htm

Jewkes Rachel, 2002. "Intimate partner violence: causes and prevention". **The Lancet**, vol. 359: 1423 –1429.

Jewkes Rachel, Loveday Penn-Kekana, Jonathan Levin, Matsie Ratsaka and Margaret Schrieber, 1999. "He must give me money, he mustn't beat me": Violence against women in three South African Provinces. **Medical Research Council Report.**

Jick Todd, 1983. " Mixing qualitative and quantitative methods: triangulation in action', in John Van Maanen (ed.), **Qualitative Methodology**. Sage Publications.

Johnson Holly, 2001. "Contrasting views of the role of alcohol in cases of wife assault". **Journal of Interpersonal violence**, vol.16, no. 1. Sage Publications

Khana Renu, Korrie De Koning, Swati Pongurlekar, Anagha Pradhan, Usha Ubale, 2000. "Sexual Coercion and Reproductive Health Problems in Slum Women of Mumbai: Role of the Health Care Provider. A paper presented at Reproductive Health in India: New Evidence and Issues; Tata Management Training Centre, Pune, Mahastra, India . February 28 to March 1, 2000.

Kim, J and Motsei, M, 2002. "Women enjoy punishment": attitudes and experiences of gender-based violence among PHC nurses in rural South Africa". http://www.rho.org/html/gsh_progexamples.thm

Maharaj Pranitha, 2001. "Male attitudes to family planning in the era of HIV/AIDS: Evidence from KwaZulu-Natal, South Africa. **Journal of Southern African Studies**, vol.27, no .2: 245-257.

Mannathoko Changu, 1992. "Feminist theories and the study of gender issues in Southern Africa" in **Gender in Southern Africa: conceptual and theoretical issues**, Ruth Meena (ed.). Sapes Books.

Manzini Ntsiki, 2001. "Sexual initiation and child bearing among adolescent girls in KwaZulu Natal, South Africa. **Reproductive Health Matters**, vol.9, no. 1: 44-52.

Mathews Shanaaz and Abrahams Naeemah, 2001." Combining Stories and Numbers: An analysis of the impact of the Domestic Violence Act (No. 116 of 1998) on women. **Medical Research Council Report.**

Mauricio Anne and Gormley Barbara, 2001. "Male perpetration of physical violence against female partners: the interaction of dominance needs and attachment insecurity". **Journal of Interpersonal violence**, vol.16, no.10. Sage Publications

Meer Fatima, Skweyiya Sayo, Jolobe Sheila, Westmore Jean and Meer Shanim, 1991. **Black-Woman-Worker**. Madiba Publications (institute for Black Research)

Mies Maria, 1986. **Patriarchy and Accumulation on a world scale: women in the International Division of labour**. Zed Books Ltd.

Mitchell Juliet and Oakley Ann, 1986. **What is feminism?** Basil Blackwell Ltd.

Moore Melissa, 1999. "Reproductive Health and Intimate Partner Violence". **Family Planning Perspectives**, vol.31, no. 6: 302-312.

Naidoo Renelle, 2002. "Trauma of the abused: victims tell of anguish", **The Post**, May 15 –17.

National Population Unit, 2000. **The State of South Africa's population report: Population, Poverty and Vulnerability**. Department of Social Development, South Africa.

Orubuloye I.O., Caldwell John and Caldwell Pat, 1993. "African women's control over their sexuality in an era of AIDS: a study of the Yoruba of Nigeria". **Social Science and Medicine,** vol. 37, no. 7:859 –872..

Population reports, 2002. "Ending violence against women". Series L, No. 1. http://www.jhuccp.org/pr/111edsum.stm

Preston-Whyte Eleanor, 1995. 'Bring us the female condom': HIV intervention, gender and political empowerment in two South African communities. **Health Transition Review**, Supplement to Vol.5.

Soskolne Varda, Sevgi O. Aral, Lawrence S. Magder, Deborah S. Reed, G. Stephen Bowen, 1991. "Condom use with regular and casual partners among women attending family planning clinics". **Family Planning Perspectives**, vol.23, no. 5:222 - 225.

Speak, 1988. Breaking the silence: women say, our men must stop beating us. No. 19, April – May.

Statistics South Africa, 2000. **Quantitative research findings on rape in South Africa.**

Ulin Priscilla, 1992. "African women and AIDS: Negotiating behavioural change". **Social Science and Medicine**, vol. 34, no. 1: 63-73.

UNAIDS, 2002. "Global estimates of HIV/AIDS epidemic as of end 2001. http://www.unaids.org/barcelona,presskit/barcelona%20report/Global_estimate.html

UNAIDS, 2002. "HIV/AIDS and gender-based violence" www.unaids.org/gender/docs/Gender%20package/GenderBasedViolence.pdf

Varga Christine and Makubalo Lindiwe, 1996. "Sexual non-negotiation". **Agenda** 28: 31 –38.

Varga Christine, 1997. "Sexual decision-making and negotiation in the midst of AIDS: youth in KwaZulu Natal , South Africa. **Health Transition Review**, Supplement 3 to volume 7, 1997, 45-67.

Varga Christine, 1999. "South African young people's sexual dynamics: Implications for behavioural responses to HIV/AIDS in **Resistances to behavioural change to reduce HIV/AIDS,** Chapter 2, 13-34.

Walby Sylvia, 1990. **Theorizing Patriarchy**. Basil Blackwell Ltd.

Watts Charlotte and Zimmerman Cathy, 2002. "Violence against women: global scope and magnitude". **The Lancet**, Vol.359, No. 6:1232-1237

WHO, 2002. Violence against women information pack: a priority health issue. http://www.who.int/frh-whd/VAW/infopack/English/VAW_infopack.htm

Wood Katherine and Jewkes Rachel, 1997. "Violence, rape, and sexual coercion: Everyday love in a South African township. **Gender and Development**, vol. 5, no. 2:41-46.

Wood Katherine, Maforah Fidelia and Jewkes Rachel, 1998. "He forced me to love him": putting violence an adolescent sexual health agendas. **Social Science and Medicine**, vol. 47, no. 2: 233-242.

Worth Dooley, 1989. "Sexual decision-making and AIDS: why condom promotion among vulnerable women is likely to fail". **Studies in Family Planning**, vol.20, no. 6.